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Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

CIGNA HEALTHCARE OF CONNECTICUT, INC.,

Petitioner,

v.

ROBERT S. NAPOLETANO, ET AL. and
F. BARRETT HOLLIS, ET AL.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE SUPREME COURT OF CONNECTICUT

PETITION FOR WRIT OF CERTIORARI

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110 pp

QUESTIONS PRESENTED FOR REVIEW

1. Whether the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.*, preempts state law claims by participants of an employee welfare benefit plan to enforce the terms of the plan or remedy alleged misrepresentations about plan benefits.

2. Whether ERISA preempts state law causes of action for reinstatement and other relief asserted by physicians terminated from a network which provides services to ERISA plans.

PARTIES TO THE PROCEEDING

All parties to the proceedings below are parties before this Court. The petitioner is CIGNA HealthCare of Connecticut, Inc. The respondents are F. Barrett Hollis, Vinetta Hollis, Elaine Arnett, Ellen Gentile, Darlene Chiloyan, Margaret Cooper, Richard A. Johnson, Sharon W. Johnson, Don Ludwinowicz, Robert S. Napoletano, Jeffrey B. Steckler, Terrence K. Donahue, Robert Cosentino, Raphael Cooper, Paul Ceplenski, Ijaz Shafi, David Bass and David Belman.

Pursuant to Rule 29.6 of the Rules of this Court, petitioner CIGNA HealthCare of Connecticut, Inc. states that it is a wholly-owned subsidiary of CIGNA Health Corp., which is a wholly-owned subsidiary of Connecticut General Corporation, which is a wholly-owned subsidiary of CIGNA Corporation, a publicly held corporation. CIGNA HealthCare of Connecticut, Inc. has no subsidiaries.

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v.

ROBERT S. NAPOLETANO, ET AL. and
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Respondents.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE SUPREME COURT OF CONNECTICUT

PETITION FOR A WRIT OF CERTIORARI

CIGNA HealthCare of Connecticut, Inc. respectfully requests that a writ of certiorari be issued to review the judgment of the Supreme Court of Connecticut entered on July 23, 1996.

OPINIONS BELOW

The opinion of the Superior Court of Connecticut dated December 5, 1994 is not reported. (App. 45a.) The

opinion of the Supreme Court of Connecticut was issued on July 23, 1996 and is reported at 238 Conn. 216 and 680 A.2d 127. (App. 1a.) The orders of the Supreme Court of Connecticut denying the motions for reargument *en banc* are unreported. (App. 66a-67a.)

JURISDICTION

The Supreme Court of Connecticut entered its judgment in this case on July 23, 1996. (App. 1a.) Petitioner timely sought rehearing by that Court, and that request was denied on September 18, 1996. (App. 66a-67a.) This Court's jurisdiction to review the final judgment of the Supreme Court of Connecticut is invoked pursuant to 28 U.S.C. § 1257(a).

STATUTORY PROVISIONS INVOLVED

The statutory provisions involved are the Connecticut Unfair Trade Practices Act, Conn. Gen. Stat. § 42-110a, *et seq.* (1992 & Supp. 1996), the Connecticut Unfair Insurance Practices Act, Conn. Gen. Stat. § 38a-815, *et seq.* (1992 & Supp. 1996), the Connecticut Managed Care Act, Conn. Gen. Stat. § 19a-166b (Supp. 1996), and the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.* The respective relevant provisions are set out at App. 68a-73a.

STATEMENT OF THE CASE

Petitioner CIGNA HealthCare of Connecticut, Inc. ("CHC") was at all relevant times a federally qualified and state authorized health maintenance organization ("HMO") that provides prepaid health care coverage to its subscribers through a network of selectively contracted medical providers. Petitioner directly contracts with physicians, hospitals, and others to obtain services for HMO subscribers at a discounted rate from normal charges. The size of the provider network is intentionally limited so that each provider can expect to receive a substantial patient volume from among HMO subscribers. This increased patient volume, in turn, provides an incentive to the network providers to discount their fees and to agree to participate in various quality and utilization management programs. Petitioner markets its HMO to employers sponsoring ERISA-covered employee welfare benefit plans that provide health care coverage to employees and their dependents.[1]

In August 1994, two separate law suits were filed in Connecticut Superior Court complaining of petitioner's conduct in managing its provider network. *Napoletano v. CIGNA HealthCare of Connecticut, Inc.* was brought by nine physicians who alleged that petitioner had removed them from the provider network in September 1993. The second

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[1] Similar networks are used to operate preferred provider organizations ("PPOs"). In PPOs, subscribers receive financial incentives to utilize network (preferred) providers, but may also seek care from non-preferred providers. The expectation is that most participants will choose to utilize the provider network, resulting in a greater volume of patients for these providers.

action, *Hollis v. CIGNA HealthCare of Connecticut, Inc.*, was brought by nine HMO subscribers -- patients of the *Napoletano* plaintiffs -- who had received health care under ERISA plans that used the CHC provider network. Both complaints asserted various state statutory and common law claims in connection with petitioner's removal of the nine physicians from its provider network.[2] As relief, both complaints sought, in addition to damages, injunctions reinstating the physicians in the network and thus requiring petitioner and the employee benefit plans that had contracted with petitioner to pay for services provided by these physicians.

In its December 1994 decision, the Superior Court granted petitioner's motion to strike all claims asserted in both actions as preempted by § 514 of ERISA, 29 U.S.C.

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[2] The *Napoletano* complaint alleged that petitioner breached its contract with the physicians by terminating them from the network "without just cause." The second and third counts alleged breach of an implied covenant of good faith and fair dealing and tortious interference with business expectancies in connection with the contract's termination. The complaint also contained claims that petitioner had violated both the Connecticut Unfair Trade Practices Act (by committing various acts of misrepresentation and false advertising in the course of engaging in the business of insurance) and the Connecticut Managed Care Act (by terminating the physicians without cause). The *Hollis* complaint also alleged that petitioner had violation the Connecticut Managed Care Act by terminating the physicians from the network without cause. In addition, it asserted that petitioner had committed violations of state statutory and common law by misrepresenting to its HMO subscribers the terms and conditions of the physicians' participation in the CHC provider network.

§ 1144. (App. 56a-64a.) Recognizing that the claims focused on the removal of the physicians from the network, the court held that they constituted "in essence, a complaint about plan administration [which] is a core ERISA concern." (App. 58a.) Accordingly, because the claims implicated plan administration (including seeking reinstatement of the physicians as eligible to provide services under ERISA plans), the court held that they necessarily "relate to" ERISA plans and were thus preempted.

On July 23, 1996, the Supreme Court of Connecticut reversed the trial court and reinstated all claims, holding that the preemptive effect of ERISA was limited "to state action that demonstrably burdens ERISA plans." (App. 29a, 39a.) Because the court found that the state law claims at issue "merely turn on requiring CIGNA to enforce the benefit plan that it has already established and is maintaining," but did not seek to modify those plans, the claims did not "relate to" the ERISA plans involved. (App. 34a-35a.) In so holding, the court interpreted this Court's recent decision in *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Co.*, 115 S. Ct. 1671 (1995) ("*Travelers*") and subsequent lower court decisions as signaling a "retreat" from ERISA preemption. (App. 24a, 27a.) Based on this perceived trend and without analyzing the plain language of the preemption clause or attempting to distinguish a uniform body of contrary precedent, the court reversed the trial court's decision and remanded for further proceedings. On September 18, 1996, the state Supreme Court denied without opinion petitioner's motions for reargument. (App. 66a-67a.)

REASONS FOR GRANTING THE WRIT

Over 114 million Americans receive health care benefits through ERISA-covered employee welfare benefit plans, and a majority of them receive their care through provider networks such as the network at issue here. The questions presented here are therefore of great concern not only to petitioner, but to other entities that manage provider networks, to plan sponsors providing their employees with such coverage, and to physicians and other health care providers who offer an increasing percentage of their services through provider networks rather than through traditional fee-for-service arrangements. These questions are also of great interest to state officials attempting to regulate managed care practices in their jurisdictions who face continuing uncertainty as to whether such regulation is preempted by ERISA. Because of the importance of these questions, and because this decision conflicts with decisions of this Court and with other federal courts, the Court should grant certiorari and reverse the decision below.

The Supreme Court of Connecticut consolidated the *Hollis* and *Napoletano* cases for argument and decision. (App. 1a, 10a.) Its decision did not distinguish between the *Hollis* and *Napoletano* claims and offered the same rationale for finding all claims not preempted -- that is, that all respondents merely sought to enforce ERISA plans rather than dictate their terms, and that such claims are properly brought under state law. (App. 18a-19a, 34a-35a.) This rationale is in direct conflict with decisions of this Court and every federal appellate circuit -- all of which hold that causes of action by ERISA plan participants to enforce the terms of

their plan are exclusively governed by ERISA's civil enforcement provisions.

The first question presented in this petition -- whether state law claims brought by ERISA plan participants to enforce a plan are preempted -- is a question that this Court has answered definitively in favor of preemption in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 54 (1987), a decision followed faithfully by the federal courts ever since. Because the holding of the Supreme Court of Connecticut is directly contrary to this Court's holding in *Pilot Life*, the Court should grant certiorari and reverse the judgment of the court below on this issue. Similarly, to the extent that these claims rest on alleged misrepresentations of plan terms, certiorari is warranted because the claims of the *Hollis* respondents are plainly preempted, especially in light of this Court's decision in *Varity Corp. v. Howe*, 116 S. Ct. 1065 (1996), which recognized an exclusively federal cause of action to remedy misrepresentations about a plan.

The remaining question presented in this petition -- whether ERISA preempts state law causes of action for reinstatement asserted by physicians terminated from a network which provides services to ERISA plans -- has not been previously addressed by this Court and presents a split between the Supreme Court of Connecticut, as a state court of last resort, and federal appellate and district courts. Because of the national importance of the preemption question presented and the conflict and disarray among the

lower courts, the Court should grant the petition and hold the claims of the *Napoletano* respondents to be preempted.[3]

I. The Decision Below Regarding the *Hollis* Claims is Directly Contrary to Decisions of this Court and of Federal Courts of Appeal

The *Hollis* respondents are ERISA plan participants who seek to force their ERISA plans to cover the cost of health care benefits obtained from physicians who had been removed from petitioner's network. Respondents allege that access to these physicians had been promised to them through plan documents as well as through other representations made to them by petitioner, acting as plan administrator. (App. 5a-7a.)

In determining that respondents' claims did not sufficiently "relate to" an ERISA plan to trigger preemption, the court below recognized that the respondents were attempting to "enforce" rights granted under their employee benefit plans. (App. 34a-35a.) It is precisely this type of

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[3] Petitioner is aware that the Court currently has under review three cases that present questions involving aspects of ERISA preemption: *California Division of Labor Standards Enforcement v. Dillingham Construction N.A., Inc.* (No. 95-789), *cert. granted*, 116 S. Ct. 1415 (Apr. 15, 1996), *De Buono v. NYSA-ILA Medical and Dental Services Fund* (No. 95-1594), *cert. granted*, 117 S. Ct. 292 (Oct. 14, 1996), and *Boggs v. Boggs* (No. 96-79), *cert. granted*, 117 S. Ct. 379 (Nov. 1, 1996). Petitioner believes that the unique and important questions presented here deserve the Court's attention and will not likely be resolved by decisions in those cases.

claim, however -- a claim to "enforce" a plan according to its terms -- that Congress intended to preempt through the interaction of ERISA's civil enforcement provisions and ERISA's preemption clause.

The plain language of ERISA's civil enforcement section provides that a plan participant or beneficiary may bring a civil action, *inter alia*, "to enforce his rights under the terms of the plan." ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B). As held by this Court, there is no question that the civil enforcement provisions of ERISA provide the exclusive mechanism to enforce rights granted to a participant through an employee benefit plan or through ERISA. *Pilot Life*, 481 U.S. at 54. In *Pilot Life*, this Court reviewed the enforcement provisions in § 502 as they relate to ERISA's preemption clause in § 514, which provides that ERISA's provisions "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." This Court concluded unanimously that ERISA preempted, in favor of its own civil enforcement mechanism, the plaintiff's attempt to enforce his benefit plan rights through state law claims for breach of contract, breach of fiduciary duties and fraud:

> The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive. This conclusion is fully confirmed by the legislative history of the civil enforcement provision.

481 U.S. at 54. *See also Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 144 (1990) (remedies under ERISA are exclusively enforced by § 502(a)).

Similarly, respondents' state law claims here "to enforce" employee benefit plans are preempted in accordance with ERISA's plain civil enforcement language, in conjunction with ERISA's preemption clause. In holding to the contrary, the decision of the Supreme Court of Connecticut is in direct conflict with decisions of this Court as well as of every federal court of appeals.[4]

Moreover, to the extent respondents' claims involve allegations of misrepresentations made by petitioner concerning benefits under ERISA plans, these claims are also preempted. Courts of appeal have uniformly held that state

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[4] *See Crull v. Gem Ins. Co.*, 58 F.3d 1386, 1391 n.3 (9th Cir. 1995) ("Claims to enforce the terms of an ERISA welfare benefit plan 'relate to' the plan, and are preempted under ERISA."); *Wolf v. Reliance Std. Life Ins. Co.*, 71 F.3d 444, 447 (1st Cir. 1995); *Anderson v. Humana Inc.*, 24 F.3d 889, 891 (7th Cir. 1994); *Alexander v. Electronic Data Sys. Corp.*, 13 F.3d 940, 943 (6th Cir. 1994); *Grimo v. Blue Cross/Blue Shield of Vermont*, 34 F.3d 148, 151 (2d Cir. 1994); *Brandon v. Travelers Ins. Co.*, 18 F.3d 1321, 1325 (5th Cir. 1994), *cert. denied*, 115 S. Ct. 732 (1995); *Donatelli v. Home Ins. Co.*, 992 F.2d 763, 764-65 (8th Cir. 1993); *Custer v. Pan Am. Life Ins. Co.*, 12 F.3d 410, 418 (4th Cir. 1993); *Winchester v. Prudential Ins. Co.*, 975 F.2d 1479, 1483 (10th Cir. 1992); *Gridley v. Cleveland Pneumatic Co.*, 924 F.2d 1310, 1315 (3d Cir.), *cert. denied*, 501 U.S. 1232 (1991); *Foltz v. U.S. News & World Report, Inc.*, 865 F.2d 364, 371 (D.C. Cir.), *cert. denied*, 490 U.S. 1108 (1989); *Howard v. Parisian, Inc.*, 807 F.2d 1560, 1565 (11th Cir. 1987).

law claims seeking to remedy misrepresentations allegedly made by a plan administrator about a participant's rights under an ERISA plan "relate to" the plan, rejecting the argument that entitlement to the benefits arises not from the plan itself but from the separate promise of extra-contractual benefits made by the administrator.[5] These courts have reasoned that in order to determine whether the communication made to a participant was false, a court would be required to interpret the ERISA plan terms to ascertain the

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[5] *See Wilcott v. Matlack, Inc.*, 64 F.3d 1458, 1464 (10th Cir. 1995) (state law misrepresentation claim is preempted where "[d]efendants' alleged misrepresentations relate directly to the nature of plaintiff's rights under the plan"); *Variety Children's Hosp., Inc. v. Century Med. Health Plan, Inc.*, 57 F.3d 1040, 1042 (11th Cir. 1995) (misrepresentation claim preempted because it "center[s] on the issue of coverage under the plan"); *Carlo v. Reed Rolled Thread Die Co.*, 49 F.3d 790, 795 (1st Cir. 1995); *Howe v. Varity Corp.*, 36 F.3d 746, 754-55 (8th Cir. 1994), *aff'd*, 116 S. Ct. 1065 (1996); *Anderson v. Humana Inc.*, 24 F.3d 889, 891 (7th Cir. 1994) ("A claim that the literature distributed as part of a plan's administration is incorrect...lies comfortably within the zone of exclusive federal control"); *Hermann Hosp. v. MEBA Medical and Benefits Plan*, 959 F.2d 569, 578 (5th Cir. 1992) (state law misrepresentation claims are preempted when based on a plan's failure to pay benefits); *Smith v. Dunham-Bush Inc.*, 959 F.2d 6, 10 (2d Cir. 1992) (common law claims of negligent misrepresentation to enforce promise to pay pension-related benefits is preempted); *Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272, 1276 (6th Cir. 1991), *cert. dismissed*, 505 U.S. 1233 (1992); *Berger v. Edgewater Steel Co.*, 911 F.2d 911, 923 (3d Cir. 1990), *cert. denied*, 499 U.S. 920 (1991); *Davidian v. Southern Cal. Meat Cutters Union*, 859 F.2d 134, 135 (9th Cir. 1988).

rights of the participant under the plan.[6] Such a claim must "relate to" the plan.

Any doubt as to whether such misrepresentation-based claims are preempted was put to rest by this Court's recent decision in *Varity Corp. v. Howe*, 116 S. Ct. 1065, 1076-79 (1996), which held that claims against a plan administrator alleging misrepresentations about plan benefits were actionable under ERISA § 502(a)(3). Because ERISA's civil enforcement provisions are exclusive, *Pilot Life*, 481 U.S. at 54, such a claim therefore cannot be maintained under state law.

The court below characterized the *Hollis* respondents' claims as based on misrepresentations about plan provisions. (App. 34a-35a.) Indeed, the court characterized these misrepresentations in the same way as this Court characterized the misrepresentations in *Varity* which it found to be actionable under ERISA. The *Varity* Court noted that the misrepresentations at issue concerned "detailed plan information [provided] in order to help [plan beneficiaries] decide whether to remain with the plan." 116 S. Ct. at 1067. Likewise, here reliance on the alleged misrepresentations (concerning participants' rights under their plans to continuity of care from a particular physician) was "[o]ne of the alleged reasons that the *Hollis* plaintiffs became or remained members of this plan." (App. 35a.) Therefore, just as the misrepresentation claims brought in *Varity* are encompassed

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[6] *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. at 139-40 ("the existence of a pension plan is a critical factor in establishing liability").

by ERISA's exclusive civil enforcement provision, *e.g.*, state a claim for breach of fiduciary duty pursuant to ERISA § 502(a)(3), so too are the claims at issue here.

II. The Decision Below Regarding the *Napoletano* Claims is in Direct Conflict with Decisions of Federal Courts

The *Napoletano* respondents are physicians who were terminated from petitioner's provider network and seek reinstatement to that network. Once reinstated, they would be authorized to seek reimbursement from their patients' (the *Hollis* respondents') ERISA plans for services provided to those patients. A similar claim, seeking an identical remedy, was held preempted by the Sixth Circuit in *Zuniga v. Blue Cross and Blue Shield of Michigan*, 52 F.3d 1395 (6th Cir. 1995), creating a direct conflict in authority between a state court of last resort and a federal court of appeals.

The plaintiff in *Zuniga* was a psychiatrist terminated from a provider network administered by Blue Cross, through which he had provided health care to ERISA plan participants. He alleged that Blue Cross had violated various state and federal laws and had breached a settlement agreement in terminating him from the network and sought an injunction requiring reinstatement. The Sixth Circuit held that the plaintiff's state law breach of contract claim (the only claim at issue on appeal) involved the "reason for denial of his application to be an authorized provider for the [ERISA plan]," and thus clearly related to the plan.

> It is not the label placed on a state law claim that determines whether it is preempted, but whether

> in essence such a claim is for the recovery of an ERISA plan benefit. That is exactly what Zuniga seeks here, the payment of benefits under the plan for his treatment of covered patients....Further, ERISA's civil enforcement provision clearly provides this type of remedy. Although this remedy is not available to Zuniga, that does not mean that no remedy exists.

52 F.3d at 1401 (citations omitted).

A similar conclusion was reached in *Adnan Varol, M.D., P.C. v. Blue Cross and Blue Shield of Michigan*, 708 F. Supp. 826 (E.D. Mich. 1989). Plaintiffs in *Adnan Varol* were participating physicians in defendant's network through which they provided services to ERISA plan participants. They alleged that the conditions of their participation in the network violated various state statutory and common laws. The court found that the state law claims "related to" the plan within the meaning of § 514, stating that

> [w]hile it may appear that this case represents a fight between plaintiffs and [Blue Cross], two parties who are not related directly to the employee-benefit plan, this is only superficially true. It is only because the Plan and its provider agreements require these parties to be in contract....[T]he fact is that [Blue Cross] is acting as the administrator of the Plan and the provider contracts...are merely the means for carrying out the benefit Plan.

708 F. Supp. at 832.[7]

As in *Zuniga*, "the relief [respondents] seek is to be reinstated as a preferred provider, which means being paid under the terms of the plans for [their] treatment of covered patients." 52 F.3d at 1402. Therefore, the *Napoletano* respondents' claim of entitlement to continued participation in the provider network unquestionably "relates to" the employee benefit plans that use that network and should be preempted.

III. The Decision Below Presents Substantial Questions of National Significance

Resolution of the questions presented is urgently needed because of their impact on health care benefits received by the majority of American workers and their families. An estimated 114 million Americans receive health care benefits through employee welfare benefit plans subject to ERISA.[8] So prevalent has the use of provider networks

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[7] *See also Stewart v. Stearman*, 743 F. Supp. 793, 796 (D. Utah 1990) (because provider agreement was an integral part of the employee benefit plan, ERISA's remedial provisions governed any dispute concerning this relationship); *Blue Cross and Blue Shield of Ala. v. Peacock's Apothecary, Inc.*, 567 F. Supp. 1258, 1267 (N.D. Ala. 1983) (same).

[8] *See* U.S. General Accounting Office, Health, Education, and Human Services Div., *Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA* (GAO/HEHS-95-167) (1995) ("1995 GAO Report") at 2, 45. *See also* Employee Benefit Research Institute Education and Research Fund, *EBRI Databook*

become in these plans that recent government statistics show that they are available to upwards of 90 million persons who are participants or beneficiaries in ERISA welfare plans,[9] and over 70 million individuals are enrolled in network-based managed care through employer-provided insurance.[10]

Concurrent with the expansion of provider networks in the delivery of health care benefits to ERISA plan participants has been a rise in the number of law suits challenging the administration of these networks. Because the majority of Americans that receive health care benefits do so under ERISA-covered employee benefit plans, most of the suits asserting state law causes of action have involved questions of ERISA preemption. As this Court noted as early as 1981, defining the boundaries of this preemption is not an easy task. *See Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981). The preemption analyses of lower courts have continued to diverge despite this Court's efforts to provide consistency.

In reaching its conclusion in this case, the court below extensively discussed this Court's *Travelers* decision, characterizing it as having indicated a "retreat[ ]" from this Court's previous "expansive view" of preemption. (App.

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on Employee Benefits (3d ed. 1995) at Table 8.8.

[9] *See* U.S. General Accounting Office, Human Resources Div., *Managed Health Care: Effect on Employers' Costs Difficult to Measure* (GAO/HRD-94-3) (1993) at 5-7.

[10] *See* 1995 GAO Report at 20 n.39.

27a.) Citing post-*Travelers* authority from federal courts of appeal, the court reasoned that "[a]lthough a successful claim under [the Connecticut statute] would in effect require that CIGNA continue to employ the plaintiff physicians, such a result would not have an impermissible or burdensome effect on the administration of the plan." (App. 39a.) In short, the court below concluded that *Travelers* has sufficiently changed the preemption landscape that it is now permissible for a state to regulate a plan's administration as long as that regulation is not, in a court's view, "burdensome."[11]

In contrast, other appellate courts discussing *Travelers* have properly recognized that its holding was limited to those state laws that have only an indirect, economic burden on plans. As the Ninth Circuit has recently said:

> *Travelers Insurance* may well signal the present Justices' unhappiness with the rather sweeping deregulatory effect that an expansive reading of the words 'relate to' has had. It does not, however, signal a retreat from *Pilot Life's* holding that the civil enforcement provisions of ERISA § 502(a) were intended by Congress to be exclusive. Claims to enforce the terms of an

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[11] At least one federal appellate court has interpreted *Travelers*, as did the court below, as representing a sea change in this Court's preemption jurisprudence. In *Coyne & Delany Co. v. Selman*, 98 F.3d 1457, 1466-67 (1996), the Fourth Circuit found common law claims for malpractice against a plan administrator not preempted "[i]n light of the Supreme Court's recent (and narrowing) interpretation of the scope of ERISA preemption in [*Travelers*]."

> employee welfare benefit plan 'relate to' the plan, and are preempted under ERISA.

Crull v. Gem Ins. Co., 58 F.3d 1386, 1391 n.3 (9th Cir. 1995). Similarly, the District of Columbia Circuit recently observed that "[a]lthough the *Travelers* Court cabined ERISA preemption in that one aspect [indirect economic influence], it also carefully reiterated its prior position that 'state laws providing alternative enforcement mechanisms...relate to ERISA plans, triggering preemption.'" *Board of Trustees of the Hotel and Restaurant Employees Local 25 v. Madison Hotel, Inc.*, 97 F.3d 1479, 1486 n.13 (D.C. Cir. 1996), quoting *Travelers*, 115 S. Ct. at 1678.[12]

This split in the circuits in interpreting the scope and meaning of *Travelers* goes beyond their disagreement over whether *Travelers* was intended by this Court to "indicate[] a retreat from preemption." Rather, they squarely conflict over whether, after *Travelers*, state law, including claims based on state law, may directly regulate plan administration. The two analyses cannot be reconciled.

Also paralleling the growth in the provision of network-based managed care to ERISA plan participants has been the proliferation of state legislation regulating the

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[12] *See also CIGNA Healthplan of La., Inc. v. Louisiana*, 82 F.3d 642, 649 (5th Cir.) (emphasizing the "limited nature of [*Travelers*'] holding"), *cert. denied*, 117 S. Ct. 387 (1996); *McFarland v. Union Cent. Life Ins. Co.*, 907 F. Supp. 1153, 1159 (E.D. Tenn. 1995) (expressly rejecting plaintiff's argument that *Travelers* "pull[ed] back from an unending expansion of federal jurisdiction" and instead held that *Travelers* "expressly reaffirmed prior authority").

contracting practices of networks with their member providers. Some 25 states have enacted "any willing provider" laws which prohibit a network from selectively contracting with providers at all.[13] Other states regulate a network's contracting practices by, for example, prohibiting "without cause" terminations or requiring that the network's provider agreements include specific terms or conditions.[14] States continue to enact such laws,[15] and both states and private parties continue to bring suit to enforce laws already on the

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[13] *See* Ala. Code § 27-45-3 (Supp. 1994); Ark. Code Ann. § 23-79-114(b) (Michie Supp. 1993); Conn. Gen. Stat. Ann. § 38a-471 (West 1982); Del. Code Ann. tit. 18, § 7301 (Supp. 1994); Fla. Stat. Ann. § 408.706 (West Supp. 1995); Ga. Code Ann. §§ 33-20-16 (1976); Idaho Code § 41-3937 (Supp. 1995); 215 Ill. Comp. Stat. Ann. 5/370h (West 1993); Ind. Code Ann. § 27-8-11-3(b)-(c) (Michie 1994); Ky. Rev. Stat. Ann. § 304.17A-110 (Banks-Baldwin Supp. 1994); 1994 Mass. Acts 60, §§ 148-49, 241; 1994 Minn. Laws 2927; Miss. Code Ann. § 41-83-3 (1994); N.H. Rev. Stat. Ann. § 420-B:12(V) (Supp. 1994); 1994 N.J. Laws SB 886/AB 1221; N.C. Gen. Stat. § 58-51-37 (1994); N.D. Cent. Code § 38.2-4209(B)-(D) (1994); Ohio Rev. Code Ann. § 1742.09(B)(2) (Anderson 1996); Okla. Stat. Ann. tit. 36, § 3634 (West Supp. 1994-95); S.D. Codified Laws § 58-18-37 (Michie 1990); Tex. Ins. Code Ann. art. 20A-14(g)(h) (West 1996); Utah Code Ann. § 31A-22-617 (1991); Va. Code Ann. § 38.2-3407 (Michie Supp. 1996); Wis. Stat. Ann. § 628.36 (West 1995); Wyo. Stat. Ann. § 26-22-503(a)(1) (Michie Supp. 1995).

[14] *See* Group Health Ass'n of America, *State Managed Care Legislative Resource* (1996) (listing statutes).

[15] *Id.*

books.[16] The fact that the Connecticut Managed Care Act is one of many such statutes underscores the nationwide scope of the clash between ERISA's protection of the freedom of employee benefit plans to structure their own benefit programs and many states' efforts to restrict that freedom.

For these reasons, ERISA's goal of promoting uniform national regulation of plans, *Travelers*, 115 S. Ct. at 1677-78, has remained particularly elusive with respect to plans' utilization of provider networks. Unless the preemption questions presented here are resolved by this Court, employee benefit plans will be faced with the prospect of either litigating over preemption in multiple jurisdictions or simply foregoing implementation of provider networks, especially on a uniform nationwide basis. Absent review by this Court, litigation over ERISA preemption and laws regulating network administration will only increase, and the conflicts among the lower courts will likely only deepen.[17]

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[16] *See, e.g., American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc. and Prudential Ins. Co. of Am.*, No. 96-10084-MEL (D. Mass. filed Jan. 17, 1996) (suit by pharmacies alleging violation of Massachusetts any willing pharmacy law).

[17] Legal commentators have also noted the unanswered nature of the question presented here. *See, e.g.*, Richard C. Reuben, *In Pursuit of Health*, 82 A.B.A. J. 54, 56 (October 1996) ("Most experts say the U.S. Supreme Court will utlimately have to decide the scope of ERISA pre-emption in the HMO context to establish uniform rules."); Jesselyn A. Brown, *ERISA and State Health Care Reform: Roadblock or Scapegoat?*, 13 Yale L. & Pol'y Rev. 339, 380-81 (1995) (discussing uncertainties regarding preemption of state managed care legislation); Gary A. Francesconi, *ERISA*

Accordingly, petitioner urges the Court to grant certiorari on the questions presented in this petition.

CONCLUSION

For the foregoing reasons, the Court should grant the petition for a writ of certiorari on the questions presented.

Preemption of "Any Willing Provider" Laws -- An Essential Step Toward National Health Care Reform, 73 Wash. U. L.Q. 227 (1995) (same).

Respectfully submitted,

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December 16, 1996

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APPENDIX A

SUPREME COURT OF CONNECTICUT

Nos. 15282, 15283

ROBERT S. NAPOLETANO, et al. v.
CIGNA HEALTHCARE OF CONNECTICUT, INC.;
F. BARRETT HOLLIS, et al. v.
CIGNA HEALTHCARE OF CONNECTICUT, INC.

March 28, 1996, Argued
July 23, 1996, officially released

William J. Sweeney, Jr., with whom, on the brief, was David M. Fisher, for the appellants (plaintiffs in each case). Theodore J. Tucci, with whom, on the brief, were James A. Wade and Craig A. Raabe, for the appellee (defendant in both cases). Richard Blumenthal, attorney general, and Richard J. Lynch and Thomas J. Ring, assistant attorneys general, filed a brief for the state commissioner of health care access as amicus curiae. Lissa J. Paris, Elizabeth J. Stewart and Jeffrey S. Brody filed a brief for the Connecticut Business and Industry Association as amicus curiae. Michael D. Neubert and Peter T. Fay filed a brief for the Connecticut State Medical Society et al. as amici curiae.

Before Peters, C.J., and Callahan, Berdon, Katz and Palmer, Js.

KATZ, Associate Justice.

These cases require us to consider primarily whether an action for misrepresentation and for violations of the

Connecticut Unfair Trade Practices Act (CUTPA) pursuant to General Statutes § 42-110b,[1] the Connecticut Unfair Insurance Practices Act (CUIPA) pursuant to General Statutes § 38a-816[2] and No. 94-235 of the 1994 Public Acts

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[1] General Statutes § 42-110b provides: "Unfair trade practices prohibited. Legislative intent.

"(a) No person shall engage in unfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce.

"(b) It is the intent of the legislature that in construing subsection (a) of this section, the commissioner and the courts of this state shall be guided by interpretations given by the Federal Trade Commission and the federal courts to Section 5 (a) (1) of the Federal Trade Commission Act (15 USC 45[a][1]), as from time to time amended.

"(c) The commissioner may, in accordance with chapter 54, establish by regulation acts, practices or methods which shall be deemed to be unfair or deceptive in violation of subsection (a) of this section. Such regulations shall not be inconsistent with the rules, regulations and decisions of the federal trade commission and the federal courts in interpreting the provisions of the Federal Trade Commission Act.

"(d) It is the intention of the legislature that this chapter be remedial and be so construed."

[2] General Statutes § 38a-816 provides in relevant part: "Unfair practices defined. The following are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

"(1) Misrepresentations and false advertising of insurance policies. Making, issuing or circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement, sales presentation, omission or comparison which: (a) Misrepresents the benefits, advantages, conditions or terms of any insurance policy; (b) misrepresents the dividends or share of the surplus to be received, on any insurance policy; (c) makes any

(P.A. 94-235),[3] as alleged by the plaintiffs in *Hollis v.*

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false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy; (d) is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any life insurer operates; (e) uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof; (f) is a misrepresentation for the purpose of inducing or tending to induce to the lapse, forfeiture, exchange, conversion or surrender of any insurance policy; (g) is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or (h) misrepresents any insurance policy as being shares of stock."

[3] Number 94-235 of the 1994 Public Acts provides in relevant part: "An Act Concerning Managed Care. . . .

"(b) All preferred provider networks shall file with the commission on hospitals and health care prior to the start of enrolment. Any preferred provider network existing as of October 1, 1993, shall file within sixty days of said date. All networks shall annually update said filing by July first commencing July 1, 1994. The filing required by such network shall include the following information, except where such information is filed with the insurance department . . . (2) A general description of the preferred provider network, including its geographical service area, the names of the hospitals included in the network and the names listed by specialty, of the providers included in the network. . . .

"(e) (1) Each preferred provider network shall file with the commission on hospitals and health care and make available upon request from a provider, the general criteria for its selection or termination of health care providers. Disclosure shall not be required of criteria deemed by the network to be of a proprietary or competitive nature that would hurt the network's ability to compete or to manage health services. For purposes of this section, disclosure of criteria is proprietary or anticompetitive if

CIGNA Healthcare of Connecticut, Inc., and whether an action for breach of contract, breach of an implied covenant

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it has the tendency to cause health care providers to alter their practice pattern in a manner that would circumvent efforts to contain health care costs and is proprietary if revealing criteria would cause the network's competitors to obtain valuable business information.

"(2) If a network uses criteria that has not been filed pursuant to subdivision (1) of this subsection to judge the quality and cost-effectiveness of a health care provider's practice under any specific program within the network, the network may not reject or terminate the provider participating in that program based upon such criteria until the provider has been informed of the criteria that his practice fails to meet."

Public Act 94-235(a)(3) defines "preferred provider network" as "an arrangement in which agreements relating to the health care services to be rendered by providers, including the amounts to be paid to the providers for such services, are entered into between such providers and a person who establishes, operates, maintains or underwrites the arrangement, in whole or in part, and shall include any provider-sponsored preferred provider network or independent practice association that offers network services. A preferred provider network shall not include a workers' compensation preferred provider organization established pursuant to Section 31-279-10 of the regulations of Connecticut state agencies or an arrangement relating only to health care services offered by providers to individuals covered under self-insured Employee Welfare Benefit Plans established pursuant to the federal Employee Retirement Income Security Act of 1974 as from time to time amended."

Public Act 94-235(a)(4) defines "provider" as "an individual or entity duly licensed or legally authorized to provide health cane services."

We note that P.A. 94-235 has been codified at General Statutes § 19a-166b. Because the parties refer to the Public Act rather than the statute, we do the same for purposes of consistency.

of good faith and fair dealing, tortious interference with business expectancies and violations of CUTPA and P.A. 94-235, as alleged by the plaintiffs in *Napoletano v. CIGNA Healthcare of Connecticut, Inc.*, are preempted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 et seq.

The plaintiffs in *Hollis* are patients who had commenced treatment with the plaintiff physicians in *Napoletano*. These physicians participated in the health care network offered by the defendant, CIGNA Healthcare of Connecticut, Inc. (CIGNA). After medical treatment had begun, and although the plaintiff patients had been provided with various assurances that their physicians, who met CIGNA's credentialing standards, would continue to participate in their health care plans, the plaintiff physicians were unilaterally terminated from the network.

Specifically, the nine plaintiffs in *Hollis* filed a thirty-six count complaint. F. Barrett Hollis, typical of the eight other plaintiffs,[4] alleged that he had commenced medical treatment

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[4] The causes of action of the remaining eight plaintiffs are substantially similar. Each plaintiff, either through his or her own employment or that of a spouse, was a participant in a CIGNA health plan. Each received treatment from a physician who, at the time treatment commenced, participated in CIGNA'S health care network. Thereafter, according to the allegations by each plaintiff, CIGNA removed the physicians treating each of the plaintiffs and engaged in a course of conduct that was substantially similar to what Hollis has alleged.

The other plaintiffs in the *Hollis* case are Vinetta Hollis, Elaine Arnett, Ellen Gentile, Darlene Chiloyan, Margaret Cooper, Richard Johnson, Sharon Johnson and Don Ludwinowicz.

with a physician who participated in CIGNA's health care providers network and who was subsequently unilaterally removed by CIGNA from its list of participating physicians. Specifically, Hollis alleged that several months alter his treatment for cancer had begun, CIGNA sent him a letter announcing changes to its network that CIGNA said would help it to achieve its goal of establishing a "comprehensive network of quality doctors who meet [its] credentialing standards. . . ." Because his doctor satisfied CIGNA's criteria but was nevertheless removed from its list, Hollis alleged that this letter misrepresented the credentialing standards. Three months later, CIGNA sent Hollis a second letter stating that should his doctor choose not to reenroll in its plan, Hollis' care would be transferred to another participating provider. According to Hollis, because his physician's removal from the network had been unilateral, this letter was also false. CIGNA then placed an advertisement in the Hartford Courant misrepresenting which physicians had been allowed to file applications to reenroll in CIGNA's network. The advertisement contained the name of Hollis' physician. Additionally, CIGNA sent Hollis a directory of providers, which included his physician, but failed to inform enrollees in its plan that participating physicians could be removed from the list without notice. On the basis of these alleged unfair and deceptive acts of misrepresentation and false advertising, Hollis alleged that CIGNA violated CUTPA and CUIPA.[5] Additionally, Hollis

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[5] Although it appears from the amended complaint in *Hollis* that the plaintiffs are bringing separate causes of action under CUTPA and CUIPA, they explain in their brief and in their reply brief to this court that their "CUIPA [counts] . . . are incorporated

alleged that CIGNA had violated P.A. 94-235 by removing his physician from its provider network without advising Hollis of its criteria for removal and despite having listed his physician as a CIGNA provider with the commission on hospitals and health care (commission). Finally, Hollis alleged that CIGNA had committed acts of misrepresentation by removing Hollis' physician from its provider network even though, in the material it had filed with the commission, CIGNA had listed his physician's name and had failed to indicate that it could remove him without notice.

In his demand for relief as to the alleged violations of CUTPA, CUIPA and the allegation of misrepresentation, Hollis sought "monetary damages in excess of $ 15,000.00 exclusive of interest and costs," "such other equitable relief as the Court deems necessary and proper," and, with respect to the CUTPA and misrepresentation counts, punitive damages pursuant to General Statutes § 42-110g(a) and reasonable attorney's fees pursuant to § 42-110g(d). As to the alleged violation of P.A. 94-235, Hollis sought a

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in [their] CUTPA counts." This is the same response they offered to CIGNA's motion to strike, in which CIGNA claimed that there is no private cause of action under CUIPA independent of CUTPA. The trial court never addressed this claim in its memorandum of decision, concluding instead that all of the plaintiffs' claims were preempted by ERISA. In light of the plaintiffs' description of their claims, we need not resolve CIGNA's claim that there is no independent private cause of action under CUIPA. See *Lees v. Middlesex Ins. Co.*, 229 Conn. 842, 847 n.4, 850 n.10, 643 A.2d 1282 (1994) (this court declined to consider defendant's claim that CUIPA does not create private cause of action where CUTPA and CUIPA claims not independent).

declaratory judgment to determine whether CIGNA had violated P.A. 94-235. He requested that his physician be reinstated as a participant in CIGNA's health care plan. Finally, Hollis sought such other equitable relief as the court deemed appropriate.

The nine plaintiffs in *Napoletano* were the physicians who had treated the plaintiffs in *Hollis*.[6] In a forty-five count complaint, each plaintiff alleged that he was a physician licensed to practice in Connecticut, that he had been a participating physician in the CIGNA health care network, having contracted with CIGNA through Pro Care Independent Practice Association, Inc. (Pro Care),[7] but that, despite satisfying all of CIGNA's credentialing standards, he had been unilaterally terminated without just cause. Each plaintiff also alleged that although he continues to be board certified in his area of specialty and continues to satisfy CIGNA's credentialing standards, he has been denied the opportunity to reenroll as a participating physician in the CIGNA network. Additionally, the complaint alleges that CIGNA had misrepresented to the plan beneficiaries, as well as to each plaintiff, that each plaintiff would remain in its directory of providers throughout the length of CIGNA's annual contract with the patient, that each plaintiff would

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[6] The other plaintiffs in the *Napoletano* case are Jeffrey Steckler, Terrence K. Donahue, Robert Cosentino, Raphael Cooper, Paul Ceplenski, Ijaz Shafi, David Bass, and David Belman, all of whom are physicians.

[7] CIGNA contracted with Pro Care to create a preferred provider network through which services to employee benefit plans would be provided. Public Act 94-235(a)(3) defines "preferred provider network." See footnote 3.

have the choice whether to reenroll, and that it would be the decision of each plaintiff whether to reenroll. In light of this alleged conduct by CIGNA, the plaintiffs claim that CIGNA breached its contract with each plaintiff, breached its obligation to deal in a manner consistent with good faith and fair dealing, tortiously interfered with each plaintiff's business expectancies, and violated CUTPA. Finally, by removing each plaintiff from CIGNA's plan while being listed as a provider in CIGNA's filing with the commission as mandated by P.A. 94-235, by failing to include in that filing the name and address of the person to whom the physicians could apply for participation in the network, and by rejecting each plaintiff without advising him of the criteria employed, CIGNA allegedly violated P.A. 94-235.

In connection with the common law claims for breach of contract, breach of good faith and fair dealing and tortious interference with business expectancies, each plaintiff sought "monetary damages in excess of $15,000.00 exclusive of interest and costs" and "such other equitable relief as the Court deems necessary and proper." For the CUTPA violation, each plaintiff requested monetary damages, punitive damages pursuant to § 42-110g(a), reasonable attorney's fees pursuant to § 42-110g(d) and such other equitable relief as is appropriate. Each plaintiff also sought a declaratory judgment to determine whether CIGNA's actions constituted violations of P.A. 94-235, to compel CIGNA's compliance with the requirements of the act, to preclude each plaintiff's termination from the network based upon CIGNA's previous noncompliance with the act and such other equitable relief as is appropriate.

CIGNA moved to strike all counts of both the *Hollis* and

Napoletano complaints, claiming that they were preempted by ERISA.[8] The trial court, in a consolidated memorandum of decision, agreed and accordingly, granted CIGNA's motions to strike.[9] The plaintiffs in both cases appealed from the judgment of the trial court to the Appellate Court, and we transferred the appeal to this court pursuant to Practice Book § 4023 and General Statutes § 51-199(c).

I

Following the filing of briefs in this appeal, sua sponte, we ordered the parties to file supplemental briefs addressing the following question: "Did all interested persons have reasonable notice of this action as required by Practice Book § 390 (d)? If not, did the trial court have jurisdiction to consider [CIGNA's] motions to strike?"

Practice Book § 390 provides in relevant part that "the court will not render declaratory judgments upon the complaint of any person . . . (d) unless all persons having an interest in the subject matter of the complaint are parties to the action or have reasonable notice thereof." This court has consistently required strict adherence to this rule. *Hopkins v. Pac*, 176 Conn. 318, 319, 407 A.2d 979 (1978). Failure to comply with § 390(d) deprives the trial court of subject matter jurisdiction to render a declaratory judgment. *Serrani*

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[8] Additionally, CIGNA claimed that there was no private cause of action under P.A. 94-235 and that, even if one were to exist, the plaintiffs had failed to state a claim under the act.

[9] The trial court concluded that ERISA preempts any action under P.A. 94-235 by assuming, without deciding, that a cause of action exists.

v. Board of Ethics, 225 Conn. 305, 308, 622 A.2d 1009 (1993).

"This rule . . . is not merely a procedural regulation. It is in recognition and implementation of the basic principle that due process of law requires that the rights of no man shall be judicially determined without affording him a day in court and an opportunity to be heard. *Kolenberg v. Board of Education*, 206 Conn. 113, 124, 536 A.2d 577, *cert. denied*, 487 U.S. 1236, 108 S. Ct. 2903, 101 L. Ed. 2d 935 (1988), quoting *Benz v. Walker*, 154 Conn. 74, 77, 221 A.2d 841 (1966). It is the settled rule of this jurisdiction, if indeed it may not be called an established principle of general jurisprudence, that no court will proceed to the adjudication of a matter involving conflicting rights and interests, until all persons directly concerned in the event have been actually or constructively notified of the pendency of the proceeding, and given reasonable opportunity to appear and be heard. *Connecticut Ins. Guaranty Assn. v. Raymark Corporation*, [215 Conn. 224, 229, 575 A.2d 693 (1990)], quoting *Ackerman v. Union & New Haven Trust Co.*, 91 Conn. 500, 508, 100 A. 22 (1917)." (Internal quotation marks omitted.) *State v. Carey*, 222 Conn. 299, 308, 610 A.2d 1147 (1992), *rev'd on other grounds*, 228 Conn. 487, 636 A.2d 840 (1994). Consequently, all persons who have a direct interest in the subject matter of the action are required to be made parties or to have reasonable notice of the action, even if their presence is not necessary to a decision of the issues between the parties of record.[10] *Benz v. Walker*, supra, at

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[10] Parties are considered "indispensable when they not only have an interest in the controversy, but an interest of such a nature that a final decree cannot be made without either affecting that

78, 221 A.2d 841.

The arguments by all the parties urging this court to conclude that the trial court had jurisdiction and to reach the merits are persuasive. The parties first argue that the trial court had jurisdiction to decide the motion to strike without providing notice to any additional parties because the requirements of Practice Book § 390 (d) were never triggered. They contend that, because the court never reached the merits of the declaratory judgment claim, having concluded that the actions were preempted by ERISA, the court was not required to reach the question of whether all interested persons had been given notice. See *Bourdieu v.*

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interest, or leaving the controversy in such condition that its final [disposition] may be . . . inconsistent with equity and good conscience." (Internal quotation marks omitted.) *Sturman v. Socha*, 191 Conn. 1, 6, 463 A.2d 527 (1983); *accord Stamford Ridgeway Associates v. Board of Representatives*, 214 Conn. 407, 439, 572 A.2d 951 (1990). Indispensable parties must be joined because due process principles make it "essential that [such parties] be given notice and an opportunity to protect [their] interests by making [them] a party to the [action]." *Fong v. Planning & Zoning Board of Appeals*, 212 Conn. 628, 634, 563 A.2d 293 (1989). Necessary parties, in contrast, are those "persons having an interest in the controversy, and who ought to be made parties, in order that the court may act on that rule which requires it to decide on, and finally determine the entire controversy, and do complete justice, by adjusting all the rights involved in it . . . But if their interests are separable from those of the parties before the court, so that the court can proceed to a decree, and do complete and final justice, without affecting other persons not before the court, the latter are not indispensable parties." (Internal quotation marks omitted.) *Sturman v. Socha*, supra, 191 Conn. at 6-7.

Pacific Western Oil Co., 299 U.S. 65, 70-71, 57 S. Ct. 51, 81 L. Ed. 42, *reh. denied*, 299 U.S. 622, 57 S. Ct. 228, 81 L. Ed. 458 (1936) (inquiry into status of absent parties where complaint falls to state cause of action unnecessary); *Calcote v. Texas Pacific Coal & Oil Co.*, 157 F.2d 216, 221 (5th Cir.), *cert. denied*, 329 U.S. 782, 67 S. Ct. 205, 91 L. Ed. 671 (1946) (inquiry into absence of indispensable parties wholly gratuitous where cause of action not stated in complaint). This distinction is significant because if we were to disagree with the trial court in this case on the issue of preemption, the plaintiffs could pursue further procedural efforts to cure any defect regarding the notice requirement on remand. See *Mannweiler v. LaFlamme*, 232 Conn. 27, 36, 53 A.2d 168 (1995) ("unlike other jurisdictional defects implicating the trial court's subject matter jurisdiction . . . the bringing of a declaratory judgment action is not itself precluded by a failure to comply with the notice requirement" [internal quotation marks omitted]).[11]

All parties also argue that, even if the trial court had been required to determine whether § 390(d) had been complied with, all persons interested in the subject matter of the case at the time of the motions to strike were parties to the action.[12] We conclude that all interested persons were

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[11] Because we conclude, however, that all interested persons were parties in these cases, we need not address the claim that this issue is premature.

[12] CIGNA further argues that, even if there were additional interested persons beyond the parties involved in the case, those interested persons had notice of the action. This court has previously concluded that "where [interested persons] are reasonably within the reach of process and are not so numerous

parties to the action, and therefore find no jurisdictional defect.

In *Hollis*, each plaintiff allegedly was insured by CIGNA and was the patient of a physician who had been removed from the provider network. Each alleged misrepresentation by CIGNA and claimed damages resulting from the interruption of a particular course of treatment with his or her physician. The record does not indicate that there are other patients who could claim damages based upon similar circumstances. Similarly, in *Napoletano*, there is no indication that there are other physicians who treated patients enrolled in CIGNA's health care plan and who are no longer in the provider network. Accordingly, we agree that the actions in the present case are personal to the named parties and all persons with an interest in the subject matter have been named. Cf. *Mannweiler v. LaFlamme*, supra, 232 Conn. at 33, 653 A.2d 168 (unnoticed lot owners were classic "indispensable parties" because resolution of issues regarding restrictive covenants and alleged common scheme

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that it would impose an unreasonable burden upon the plaintiff they should be made parties; but if they or some of them are not reasonably available for service or to summon them or all of them into the action would put upon the plaintiff a burden he ought not fairly to be asked to assume, the provision for reasonable notice applies." *Benz v. Walker*, supra, 154 Conn. 78. Such reasonable notice may be accomplished by an order for public notice. *Serrani v. Board of Ethics*, supra, 225 Conn. 309-10. CIGNA cites to a variety of newspapers, including the Hartford Courant, The Connecticut Post and The Herald, which contained commentary on these cases, in support of its argument that all interested persons had notice of this action. Because we conclude that all interested persons were parties, reliance on these articles is unnecessary.

of development was relevant to all deeds within development); *Connecticut Ins. Guaranty Assn. v. Raymark Corp.*, supra, 215 Conn. at 228, 575 A.2d 693 (unnoticed persons with outstanding personal injury claims against named defendant or its predecessors were "interested parties" where subject matter of complaint was insurance policy issued by insolvent insurer of named defendant).[13]

II

We next consider CIGNA's argument that the plaintiffs' claims in both *Hollis* and *Napoletano* are moot. As to Napoletano, CIGNA contends that even were this court to reverse the judgment of the trial court as to the breach of contract and covenant of good faith and fair dealing claims, the trial court could not provide the plaintiffs with any practical relief. CIGNA structured its relationship with the plaintiff physicians through Pro Care, an independent practice association that contracted with CIGNA to provide services to employee benefit plans that CIGNA administered and of which each of the plaintiff physicians was a member.

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[13] The plaintiffs argue that even if there are other potentially interested persons, the filing of amici curiae briefs on behalf of consumers, physicians and insurance companies, satisfy any concerns associated with § 390 (d) because, although they are not actual parties, the amici nevertheless fully participated in the briefing of the issues and were not "prejudiced nor otherwise adversely affected by not being joined as a party. . . ." *Hilton v. New Haven*, 233 Conn. 701, 724, 661 A.2d 973 (1995). Because we have concluded that all interested persons are parties to this case, we need not decide whether the circumstances of this case are unique within the meaning of *Hilton*. *Id.*, at 723-24, 661 A.2d 973.

See footnote 7. The plaintiff physicians, consequently, were third party beneficiaries of this contract, which provided that it could be terminated at any time and, in fact, was terminated by CIGNA on September 8, 1994. Because the contract has lawfully expired, CIGNA claims that "it is impossible to judicially enforce rights to participate in a provider network under a contract that no longer exists." As to the alleged violations of P.A. 94-235, CIGNA asserts that the claims are moot because it has already complied with the act.[14]

Finally, in connection with the plaintiff physicians' tortious interference with business expectancies claim, CIGNA argues that the plaintiff physicians could not expect that a business relationship with a patient would exist beyond the expiration of the patient's health care benefits under CIGNA's health care coverage options. CIGNA claims that all of its health care options, through which employees receive health care benefits, are limited to twelve months and that CIGNA clearly had the right to change its provider network structure when it renewed its health care coverage options. Consequently, even if the plaintiff physicians were to prevail, the trial court could require CIGNA to include them in the provider network only for the remaining time that their patients had coverage benefits under the health care option chosen.

As to the plaintiffs in *Hollis*, CIGNA contends that the expiration of the annual health care coverage options for all the plaintiffs precludes the practical relief they seek. In

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[14] CIGNA made the requisite filing after the plaintiffs filed their amended complaints.

specific, CIGNA argues that the court could not reinstate the plaintiffs' physicians in a health care plan that no longer exists. Additionally, CIGNA argues that because it exercised its right to change the structure of the provider network upon the renewal of its contracts with the plaintiffs' employers, and that these new contracts do not include the plaintiff physicians as providers, the plaintiffs' claims have evaporated. We disagree that the plaintiffs in both cases are unable to obtain practical relief should they prevail.

"Mootness implicates the court's subject matter jurisdiction and is thus a threshold matter for us to resolve. . . . It is a well-settled general rule that the existence of an actual controversy is an essential requisite to appellate jurisdiction; it is not the province of appellate courts to decide moot questions, disconnected from the granting of actual relief or from the determination of which no practical relief can follow. . . . An actual controversy must exist not only at the time the appeal is taken, but also throughout the pendency of the appeal. . . . When, during the pendency of an appeal, events have occurred that preclude an appellate court from granting any practical relief through its disposition of the merits a case has become moot." (Citations omitted; internal quotation marks omitted.) *Ayala v. Smith*, 236 Conn. 89, 93-94, 671 A.2d 345 (1996).

We dispose of CIGNA's mootness claims summarily. CIGNA focuses solely on the plaintiffs' claims in both cases for injunctive relief and all but ignores their claims for redress of injury for even the limited period it contends is in

question.[15] Because each of the eighteen plaintiffs in the two cases sought far more than injunctive relief in the eighty-one counts and because each states a claim for redress for, among other things, fraudulent and deceptive behavior, which, if proven, would entitle them to punitive damages and attorney's fees, their claims are not moot.[16]

III

The next issue that we address, which is the central substantive issue in this case, involves whether the plaintiffs' claims in both *Hollis* and *Napoletano* are preempted by ERISA. Specifically, we consider whether ERISA preempts the plaintiffs' claims for misrepresentation and for violations of CUTPA, CUIPA and P.A. 94-235 in *Hollis* and whether ERISA preempts the plaintiffs' claims for breach of contract, breach of an implied covenant of good faith and fair dealing, tortious interference with business expectancies and violations of CUTPA and P.A. 94-235 in *Napoletano*. We conclude that because the claims raised by the plaintiffs do not affect or prescribe the establishment, administration, regulation or maintenance of an employee benefit plan, but, rather, merely seek to enforce the plan that CIGNA has chosen to create and administer, the claims do not "relate to"

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[15] The plaintiffs in both cases dispute CIGNA's argument that the existence of new contracts terminates certain of their claims. Because we disagree with CIGNA's interpretation of our mootness doctrine, we need not resolve this issue.

[16] As stated above, in *Hollis*, each of the nine plaintiffs asserted four causes of action, and sought injunctive relief in only one. In *Napoletano*, each of the nine plaintiffs asserted five causes of action, and sought injunctive relief in only one.

employee benefit plans within the meaning of ERISA's preemption provision. Consequently, none of the plaintiffs' claims in the two cases is preempted.

In the present cases, the trial court, on motions to strike, concluded that the plaintiffs' claims relate to an ERISA plan because they both refer to and are connected with such a plan.[17] The claims "refer to" an ERISA plan because "references to the plan abound in the . . . amended complaint." Also, the claims are "connected with" a plan "because the plaintiffs challenge the administration of the plan in question." (Emphasis in original.) The court explained that "the complaint . . . focuses on CIGNA's removal of certain physicians from its plan. This is, in essence, a complaint about plan administration. This is a core ERISA concern." (Emphasis in original.) Furthermore, the court reasoned that "allowing state law actions like the one[s] here would subject plans and plan sponsors to burdens not unlike those that the preemption clause seeks to foreclose. It is entirely foreseeable that different state courts, construing a wide array of state statutory provisions and common law principles, might develop different substantive standards governing the circumstances under which health plans could remove physicians from their lists. This would . . . require the tailoring of plans . . . to the peculiarities of the law of each jurisdiction. Such an outcome is fundamentally at odds with the goal of uniformity

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[17] The trial court first decided the CUIPA claim in *Hollis* and, thereafter, adopted the same reasoning to strike all of the remaining counts in both cases. In reaching its decision, the court presumed the existence of a private cause of action under P.A. 94-235. See part IV of this opinion.

that Congress sought to implement." (Internal quotation marks omitted.)

Our review of the trial court's decision is plenary. "The scope of our appellate review depends upon the proper characterization of the rulings made by the trial court. To the extent that the trial court has made findings of fact, our review is limited to deciding whether such findings were clearly erroneous. When, however, the trial court draws conclusions of law, our review is plenary and we must decide whether its conclusions are legally and logically correct and find support in the facts that appear in the record." (Internal quotation marks omitted.) *Westport Taxi Service, Inc. v. Westport Transit District*, 235 Conn. 1, 14, 664 A.2d 719 (1995). In this case, the trial court ruled on motions to strike. The function of a motion to strike is to test the legal sufficiency of a pleading; it admits all facts well pleaded. See Practice Book § 152. The role of the trial court was to examine the complaints, construed in favor of the plaintiffs, to determine whether the plaintiffs have stated a legally sufficient cause of action. See *Sheets v. Teddy's Frosted Foods, Inc.*, 179 Conn. 471, 472, 427 A.2d 385 (1980). Because the trial court drew conclusions of law, and did not make findings of fact, our review is plenary.

Our review of the trial court's decisions leads us into the quagmire of ERISA law. ERISA is a "comprehensive regulation of employee welfare and pension benefit plans [that] extends to those that provide 'medical, surgical, or hospital care or benefits' for plan participants or their beneficiaries 'through the purchase of insurance or otherwise.' [Section 3 (1) of ERISA], 29 U.S.C. § 1002(1). The federal statute does not go about protecting plan

participants and their beneficiaries by requiring employers to provide any given set of minimum benefits, but instead controls the administration of benefit plans, see § 2 [of ERISA], 29 U.S.C. § 1001 (b), as by imposing reporting and disclosure mandates, §§ 101-111 [of ERISA], 29 U.S.C. §§ 1021-1031, participation and vesting requirements, §§ 201-211 [of ERISA], 29 U.S.C. §§ 1051-1061, funding standards, §§ 301-308 [of ERISA], 29 U.S.C. §§ 1081-1086, and fiduciary responsibilities for plan administrators, §§ 401-414 [of ERISA], 29 U.S.C. §§ 1101-1114. It envisions administrative oversight, imposes criminal sanctions, and establishes a comprehensive civil enforcement scheme. [Sections 501-515 of ERISA], 29 U.S.C. §§ 1131-1145. It also preempts some state law. [Section 514 of ERISA], 29 U.S.C. § 1144." *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, ___ U.S. ___, ___, 115 S. Ct. 1671, 1674-75, 131 L. Ed. 2d 695 (1995).

The preemption provision of ERISA, 29 U.S.C. § 1144(a) (1994), preempts any state law that "may now or hereafter relate to any employee benefit plan. . . ."[18] (Emphasis added.) A law that "relates to" a benefit plan and that also "regulates insurance" pursuant to 29 U.S.C. § 1144(b)(2)(A)

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[18] Section 514(a) of ERISA, codified at 29 U.S.C. § 1144(a), provides in relevant part: "Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003 (a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975."

and (B) is, however, exempt from ERISA preemption.[19] Consequently, our resolution of this matter turns on whether the plaintiffs' claims "relate to" the employee benefit plans offered by CIGNA.[20]

We begin by construing the phrase "relate to" in accordance with the intent of Congress in enacting ERISA. "It is fundamental that statutory construction requires us to ascertain the intent of the legislature and to construe the

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[19] Title 29 of the United States Code, § 1144(b)(2)(A) provides: "Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

Title 29 of the United States Code, § 1144(b)(2)(B) provides: "Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies."

[20] The plaintiffs claimed at oral argument that the health care plans offered by CIGNA in this case are not "plans" within the meaning of ERISA. Although CIGNA disputes this claim, because the plaintiffs failed to preserve this argument below and failed to brief this claim, we decline to address it. *See* Practice Book § 4065; *State v. Zarick*, 227 Conn. 207, 221, 630 A.2d 565, *cert. denied*, 510 U.S. 1025, 114 S. Ct. 637, 126 L. Ed. 2d 595 (1993); *Liscio v. Liscio*, 204 Conn. 502, 507, 528 A.2d 1143 (1987).

statute in a manner that effectuates that intent. . . . In seeking to discern that intent, we look to the words of the statute itself, to the legislative history and circumstances surrounding its enactment, to the legislative policy it was designed to implement, and to its relationship to existing legislation. . . . *Petco Insulation Co. v. Crystal*, 231 Conn. 315, 321, 649 A.2d 790 (1994). In order to determine the meaning of a statute, we must consider the statute as a whole when reconciling its separate parts in order to render a reasonable overall interpretation. *Broadley v. Board of Education*, 229 Conn. 1, 6, 639 A.2d 502 (1994); *Ganim v. Roberts*, 204 Conn. 760, 763, 529 A.2d 194 (1987)." (Internal quotation marks omitted.) *Murchison v. Civil Service Commission*, 234 Conn. 35, 45, 660 A.2d 850 (1995); accord *Angelsea Productions, Inc. v. Commission on Human Rights & Opportunities*, 236 Conn. 681, 688-89, 674 A.2d 1300 (1996); see *Oklahoma v. New Mexico*, 501 U.S. 221, 235 n.5, 111 S. Ct. 2281, 115 L. Ed. 2d 207 (1991) ("we repeatedly have looked to legislative history and other extrinsic material when required to interpret a statute which is ambiguous"); *Green v. Bock Laundry Machine Co.*, 490 U.S. 504, 509-11, 109 S. Ct. 1981, 104 L. Ed. 2d 557 (1989); *Pierce v. Underwood*, 487 U.S. 552, 564-65, 108 S. Ct. 2541, 101 L. Ed. 2d 490 (1988); *Blum v. Stenson*, 465 U.S. 886, 896, 104 S. Ct. 1541, 79 L. Ed. 2d 891 (1984). Since ERISA was enacted, the United States Supreme Court has attempted to explain when a law "relates to" an employee benefit plan. Early Supreme Court cases provided

an expansive interpretation of this term.[21] In a 1983 case dealing with ERISA preemption, the court, viewing ERISA's preemption language to be clear and relying on a dictionary definition of the term "relate" stated that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan. . . .

"In fact . . . Congress used the words 'relate to' in § 514 (a) in their broad sense. To interpret § 514 (a) to [preempt] only state laws specifically designed to affect employee benefit plans would be to ignore the remainder of § 514. It would have been unnecessary to exempt generally applicable state criminal statutes from [preemption] in § 514(b), for example, if § 514(a) applied only to state laws dealing specifically with ERISA plans.

"Nor, given the legislative history, can § 514(a) be interpreted to [preempt] only state laws dealing with the subject matters covered by ERISA--reporting, disclosure, fiduciary responsibility, and the like. The bill that became ERISA originally contained a limited [preemption] clause, applicable only to state laws relating to the specific subjects covered by ERISA. The Conference Committee rejected these provisions in favor of the present language, and indicated that the section's [preemptive] scope was as broad as its language. See H.R. Conf. Rep. No. 93-1280, p. 383 (1974); S. Conf. Rep. No. 93-1090, p. 383 (1974). Statements by the bill's sponsors during the subsequent debates stressed the breadth of federal [preemption].

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[21] As will be discussed later in this opinion, the Supreme Court and lower federal courts have retreated from an expansive interpretation in more recent cases.

Representative [John] Dent, for example, stated: 'Finally, I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation.' 120 Cong. Rec. 29197 (1974). Senator [Harrison A.] Williams echoed these sentiments: 'It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law.' Id., at 29933." (Emphasis added.) *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-99, 103 S. Ct. 2890, 77 L. Ed. 2d 490 (1983).

"It is thus clear that ERISA's [preemption] provision was prompted by recognition that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities. A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them. [Preemption] ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations. See, e.g., H.R. Rep. No. 93-533, p. 12 (1973) ('[A] fiduciary standard embodied in Federal legislation is

considered desirable because it will bring a measure of uniformity in an area where decisions under the same set of facts may differ from state to state')." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11, 107 S. Ct. 2211, 96 L. Ed. 2d 1 (1987).

The Supreme Court has further concluded that "a state law may 'relate to' a benefit plan, and thereby be [preempted], even if the law is not specifically designed to affect such plans, or the effect is only indirect." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139, 111 S. Ct. 478, 112 L. Ed. 2d 474 (1990). However, "some state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Shaw v. Delta Air Lines, Inc.*, supra, 463 U.S. at 100 n.21. For example, many laws of general applicability that function irrespective of the existence of an employee benefit plan are not preempted because they are too remotely related to the plan. See *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125, 130 n.1, 113 S. Ct. 580, 121 L. Ed. 2d 513 (1992); *Ingersoll-Rand Co. v. McClendon*, supra, at 139, 111 S. Ct. at 482-83. Lastly, in cases "where federal law is said to bar state action in fields of traditional state regulation . . . [the court has] worked on the 'assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.'" (Citation omitted.) *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, supra, ___ U.S. at ___, 115 S. Ct. at 1676.

With the exception of these limitations, the United States Supreme Court until recently has generally viewed ERISA's

preemption provision broadly. In recent cases, however, the court has retreated from this expansive view.[22] In *Travelers Ins. Co.*, the court acknowledged that although "the governing text of ERISA is clearly expansive . . . if 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes [preemption] would never run its course, for 'really, universally, relations stop nowhere,' H. James, Roderick Hudson xli (New York ed., World's Classics 1980). But that, of course, would be to read Congress's words of limitation as mere sham, and to read the presumption against [preemption] out of the law whenever Congress speaks to the matter with generality." *Id.*, at ___, 115 S. Ct. at 1677.

The Supreme Court in *Travelers Ins. Co.* described the types of cases that raise preemption concerns, focusing on those scenarios in which a state law imposes a substantive mandate on an employee benefit plan. *Id.*, at ___, ___, 115 S. Ct. at 1678, 1681; see *FMC Corp. v. Holliday*, 498 U.S. 52, 60, 111 S. Ct. 403, 112 L. Ed. 2d 356 (1990) (state law dictated structure of plan); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739, 105 S. Ct. 2380, 85 L. Ed. 2d 728 (1985) (state law mandated coverage of mental health care benefits); *Shaw v. Delta Air Lines, Inc.*, supra, 463 U.S. at 96-97 (state law mandated subject of plan's benefits). The court then contrasted those cases with the

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[22] There is a general consensus that, in *Travelers Ins. Co.*, the Supreme Court indicated a retreat from preemption. *See, e.g., Crull v. Gem Ins. Co.*, 58 F.3d 1386, 1391 n.3 (9th Cir. 1995) ("[Travelers Ins. Co.] may well signal the present Justices' unhappiness with the rather sweeping deregulatory effect that an expansive reading of the words 'relate to' has had").

case then before it in which a New York statute imposed surcharges on hospital rates for patients whose commercial insurance coverage had been purchased by employee health care plans governed by ERISA. The court stated that "an indirect economic influence . . . does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself. . . . Nor does the indirect influence of the surcharges preclude uniform administrative practice or the provision of a uniform interstate benefit package if a plan wishes to provide one."[23] *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, supra, ___ U.S. at ___, 115 S. Ct. at 1679. The court summarized its conclusion as follows: "We do not hold today that ERISA [preempts] only direct regulation of ERISA plans, nor could we do that with fidelity to the views expressed in our prior opinions on the matter. See, e.g., [*Ingersoll-Rand Co. v. McClendon*, supra, 498 U.S. at 139]; *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47-48, 107 S. Ct. [1549], 95 L. Ed. 2d 39 (1987); *Shaw* [*v. Delta Air Lines, Inc.*, supra, 98, 103 S. Ct. at 2900-01].

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[23] Additionally, the court stated that "cost-uniformity was almost certainly not an object of [preemption], just as laws with only an indirect economic effect on the relative costs of various health insurance packages in a given State are a far cry from those 'conflicting directives' from which Congress meant to insulate ERISA plans. . . . Such state laws leave plan administrators right where they would be in any case, with the responsibility to choose the best overall coverage for the money. . . . [Therefore,] such state laws do not bear the requisite 'connection with' ERISA plans to trigger [preemption]." (Citation omitted.) *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, supra, ___ U.S. at ___, 115 S. Ct. at 1680.

We acknowledge that a state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and that such a state law might indeed be [preempted] under § 514. . . . [A law, however, that affects] only indirectly the relative prices of insurance policies, a result no different from myriad state laws in areas traditionally subject to local regulation, [is one] which Congress could not possibly have intended to eliminate." *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, supra, at ___, 115 S. Ct. at 1683.

Since *Travelers Ins. Co.* was decided, various courts of appeals, including the Court of Appeals for the Second Circuit, have focused on the Supreme Court's primary concerns with respect to ERISA preemption and, consequently, have followed the lead of that court by limiting ERISA preemption to state action that demonstrably burdens ERISA plans. The Court of Appeals for the Sixth Circuit stated that "Congress sought to [preempt] state laws [or state claims] that have a burdensome effect on ERISA plans. When a state law [or claim] has such an effect on a covered plan, it is [preempted]; when it does not, it is not [preempted] even if it actually refers to ERISA. Interpreting 'relates to' as being concerned with state laws' significant effects on covered plans serves Congress's purpose in enacting ERISA, [namely,] to avoid encouraging 'employers with existing plans to reduce benefits, [or] those without such plans to refrain from adopting them.'" (Emphasis added.) *Thiokol Corp., Morton International, Inc. v. Roberts*, 76 F.3d 751, 757 (6th Cir. 1996). The court in

Roberts noted that the Shaw court's definition of "relate to"--whether a law has a "connection with" or a "reference to" an ERISA plan--creates a formalistic analytical distinction. *Id.*, at 758. The court suggested, instead, that "both are simply approximations of the same test. Although in its ERISA [preemption] cases the Supreme Court analyzes state laws by first examining whether they refer to a covered plan and, if not, whether they still have some connection with a covered plan, the two categories are not analytically distinct; rather, they are two related methods of determining the fundamental question in ERISA analysis: whether the state law has an impermissible effect on a covered plan." (Emphasis added.) *Id.*

The Court of Appeals for the Seventh Circuit explained recently that a law or claim will interfere with the provisions or administration of ERISA plans if it "dictate[s] what benefits employers may offer their employees [or] interfere[s] with the manner in which those benefits are provided." (Emphasis added.) *Safeco Life Ins. Co. v. Musser*, 65 F.3d 647, 653 (7th Cir. 1995). Additionally, the Court of Appeals for the Eighth Circuit examined a series of factors to determine whether ERISA preemption applies, including whether a law or claim involves the historic police powers of the state, whether a provision of the plan is negated, whether the relationships among the primary ERISA entities--the employer, the plan, the plan fiduciaries, and the beneficiaries--are altered such that the structure of the plan is changed, and whether there is more than a tenuous or peripheral economic impact. *Boyle v. Anderson*, 68 F.3d 1093, 1099, 1102-1105 (8th Cir. 1995), *cert. denied*, ___ U.S. ___, 116 S. Ct. 1266, 134 L. Ed. 2d 214 (1996).

The Court of Appeals for the Second Circuit has also recently examined the ERISA preemption doctrine in light of *Travelers Ins. Co.* In five cases, the court has focused on the Supreme Court's concerns. Quoting from *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, supra, ___ U.S. at ___, 115 S. Ct. at 1677, the court in *O'Shea v. First Manhattan Co. Thrift Plan & Trust*, 55 F.3d 109, 113 (2d Cir. 1995), focused on Congress' goal in enacting ERISA, namely, "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law . . . [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction." (Emphasis added; internal quotation marks omitted.) The court determined that a New York statute requiring death beneficiary designations to be in writing was preempted by ERISA because the statute affected key plan documents and "had Congress chosen to impose a signature requirement, it could have done so. To impose such a requirement in New York, but not elsewhere, would frustrate ERISA's goal of establishing a unified national system to safeguard retirement benefits." *Id.*, at 114; see *Greenblatt v. Delta Plumbing & Heating Corp.*, 68 F.3d 561, 574 (2d Cir. 1995) (primary purpose of ERISA preemption is "'to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans'").

In *NYS Health Maintenance Organization Conference v. Curiale*, 64 F.3d 794, 800 (2d Cir. 1995), the court focused first on whether the law in question makes "reference to" ERISA, in specific, whether it "mentions or alludes to ERISA plans, and if the law affects ERISA plans in some

manner," such as by mandating or manipulating the contents of an insurer's benefits package. Accord *New England Health Care Employees Union v. Mount Sinai Hospital*, 65 F.3d 1024, 1032 (2d Cir. 1995). The court also focused on whether the law was impermissibly connected[24] with an ERISA plan by having "'an effect on the primary administrative functions of benefit plans, such as determining an employee's eligibility for a benefit and the amount of that benefit.'" *NYS Health Maintenance Organization Conference v. Curiale*, supra, at 801. For this to occur, the court stated that the effect must be "sufficiently disruptive to ERISA plans to merit preemption." *Id.*, at 800 n.17. Additionally, the court, reiterating *Travelers Ins. Co.*, concluded that "without evidence . . . [of] 'such acute, albeit indirect economic effects . . . as to force an ERISA plan to adopt a certain scheme of substantive coverage or to effectively restrict its choice of insurers,' . . . ERISA does not preempt. . . ." (Citation omitted.) *Connecticut Hospital Assn. v. Weltman*, 66 F.3d 413, 415 (2d Cir. 1995).

In the present cases, CIGNA argues that the claims asserted by the plaintiffs are preempted by ERISA because they "relate to" the health care plan that CIGNA administers

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[24] "[A] 'connection exists where a state statute prescribes either the type and amount of an employer's contributions to a plan . . . the rules and regulations under which the plan operates . . . or the nature and amount of the benefits provided thereunder. . . .'" *NYS Health Maintenance Organization Conference v. Curiale*, supra, 64 F.3d 801, *quoting General Electric Co. v. New York State Dept. of Labor*, 891 F.2d 25, 29 (2d Cir. 1989), *cert. denied*, 496 U.S. 912, 110 S. Ct. 2603, 110 L. Ed. 2d 283 (1990).

in that they deal with the administration of the plan.[25] CIGNA asserts that, because the plaintiffs' CUTPA, CUIPA and common law claims are based upon CIGNA's decision to restructure the health care coverage that it offers such that certain physicians would no longer be a part of the new provider network, the plaintiffs are directly challenging the propriety of the administration of the plans. CIGNA claims that the connection between the plaintiffs' claims and the ERISA plans is exemplified by the nature of the relief sought, namely, an injunction requiring CIGNA to include the physician plaintiffs in its provider network. Similarly, CIGNA argues that, with respect to the plaintiffs' claims arising under P.A. 94-235, in seeking an order to require that CIGNA include the plaintiff physicians in its provider network, the claims relate directly to the administration of the plaintiffs' employee benefit plans. We disagree.

The essence of the plaintiffs' claims do not relate to the administration of employee benefit plans. The claims and relief sought do not impermissibly affect the plans--they do not attempt to prescribe the substantive administrative aspects of a plan, such as a determination of an employee's eligibility, the nature and amount of employee benefits, the amount of an employer's contribution to a plan, and the rules and regulations under which the plan operates. See, e.g., *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, supra, ___ U.S. at ___, 115 S. Ct. at 1683; *District of Columbia v. Greater Washington Board of Trade*, supra, 506 U.S. at 130-33; *FMC Corp. v.*

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[25] CIGNA concedes that the statutory and common law causes of action are not preempted per se.

Holliday, supra, 498 U.S. at 60; *Metropolitan Life Ins. Co. v. Massachusetts*, supra, 471 U.S. at 739; *Shaw v. Delta Air Lines, Inc.*, supra, 463 U.S. at 95-100; cf. *Connecticut Hospital Assn. v. Weltman*, supra, 66 F.3d at 415; *NYS Health Maintenance Organization Conference v. Curiale*, supra, 64 F.3d at 800-801. The plaintiffs' claims do not require the administrators to operate the plans differently, they do not force a plan to adopt a certain scheme of substantive coverage, they do not tell CIGNA what type of plan to adopt, what coverage to offer, or whom to cover. As the Connecticut State Medical Society and the American Medical Association argue in their amicus brief to this court, "under the Act, an insurer, such as CIGNA, can structure its plan . . . and administer it any way it chooses; it simply must disclose, to a limited extent, what the structure of the [preferred provider network] is (by listing the providers) and how it is determined (by listing the criteria). This is not a substantive requirement, or the type which ERISA sought to [preempt]." (Emphasis in original.)

Rather than affecting or prescribing the establishment, administration, regulation or maintenance of an employee benefit plan, the plaintiffs' claims merely turn on requiring CIGNA to enforce the benefit plan that it has already established and is maintaining.[26] The *Hollis* plaintiffs' statutory and common law claims are based on CIGNA's

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[26] To the extent that a requirement that CIGNA enforce the plans as created imposes administrative costs and burdens upon the benefit plans, the Supreme Court has concluded that indirect costs and burdens do not result in preemption. *See New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, supra, 115 S. Ct. 1680.

alleged misrepresentations that their physicians chose not to continue as plan providers and that the physicians did not meet the requisite criteria. One of the alleged reasons that the *Hollis* plaintiffs became or remained members of this plan was because CIGNA had contracted with certain physicians, whose identities they knew based upon the filing that CIGNA was required to make under P.A. 94-235. The *Hollis* plaintiffs, therefore, could reasonably presume that as long as their physicians continued to meet the credentialing criteria and did not meet any of the reasons for discharge, that they would continue to be providers under the plan. Furthermore, even if P.A. 94-235 did not exist, the *Hollis* plaintiffs could reasonably expect that their physicians would continue to be providers under the plan for the duration of the physicians' contracts with CIGNA and would not be unilaterally terminated.

Similarly, the *Napoletano* plaintiffs' claims simply assert that CIGNA has failed to enforce the employee benefit plan that it administers. The *Napoletano* plaintiffs reasonably believed that they would continue to be providers under the plan as long as they met the criteria that P.A. 94-235 required that CIGNA provide or for the duration of their contracts. The *Napoletano* plaintiffs are merely asking that their relationship with CIGNA be managed in accordance with a specific filing that CIGNA has made with the state in which CIGNA was required to indicate the criteria by which it would select and could discharge providers, as well as in accordance with their one year contracts with CIGNA. This is not a case in which the *Napoletano* plaintiffs seek to force themselves into CIGNA's plan. CIGNA removed the physicians from its list of providers before their contracts had expired and without following the requirements of P.A.

94-235--it did not inform the plaintiff physicians of its criteria for discharge and did not give alternate reasons for discharging them. Neither class of plaintiffs is requesting that CIGNA change the method by which it determines which physicians will be providers under its plan--in other words, the plaintiffs are not claiming that CIGNA should change its list of criteria. Instead, the plaintiffs are merely asking that CIGNA disclose its criteria and, subsequently, adhere to them.

Significantly, CIGNA conceded during oral argument that P.A. 94-235 is not per se preempted by ERISA in that it does not directly affect plan administration and does not interfere with substantive decisions CIGNA makes with respect to structuring health benefit plans. Furthermore, at oral argument, CIGNA conceded that ERISA would not preempt a claim by the plaintiffs that CIGNA had failed to make the requisite filing with the commission pursuant to P.A. 94-235(e)(1)[27] because such a claim would be too remote to the administration of the plan. It follows logically from this concession that the plaintiffs' claim that CIGNA failed to comply with another provision of P.A. 94-235, namely, subsection (e)(2), which provides that "if a network uses criteria that [have] not been filed pursuant to subdivision (1) of this subsection to judge the quality and cost-effectiveness of a health care provider's practice under any specific program within the network, the network may not reject or terminate the provider participating in that program based upon such criteria until the provider has been informed of the criteria that his practice fails to meet," is

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[27] See footnote 3.

likewise not preempted by ERISA. CIGNA argues, however, that the difference in the relief sought in the two circumstances--in the former, it is simply that CIGNA make the appropriate filing; in the latter, it is that CIGNA pay monetary damages for the harm suffered by the plaintiffs--dictates that ERISA preempts the claim that a provider has been improperly discharged. Because the relief in the second scenario involves the payment of monetary damages, CIGNA argues, the administration of the plan is affected. We disagree with CIGNA.

The plaintiffs are not seeking monetary damages for their claim that CIGNA violated P.A. 94-235.[28] Rather, they are seeking a declaratory judgment requiring solely that CIGNA

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[28] A second reason for our conclusion is that even if the plaintiffs were seeking damages, CIGNA's argument creating a distinction between the type of relief sought is contrived. The administration of the plan is not affected in a greater way by mandating that a plan pay money damages for violating a law than by mandating that a plan make an appropriate filing according to law. In either situation, CIGNA is left "right where [it] would be in any case, with the responsibility to choose the best overall coverage for the money." *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, supra, 115 S. Ct. 1680. Where a cause of action to enforce the filing requirements of P.A. 94-235 is admittedly not preempted, CIGNA cannot thereafter argue that just because the remedy of another type of enforcement would be monetary damages, preemption suddenly applies. *See International Paper Co. v. Ouellette*, 479 U.S. 481, 498 n.19, 107 S. Ct. 805, 93 L. Ed. 2d 883 (1987) ("unless there is evidence that Congress meant to 'split' a particular remedy for [preemption] purposes, it is assumed that the full cause of action under state law is available [or preempted]").

comply with the act.[29] As we have previously stated, by

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[29] In the demand for relief under their claim for an alleged violation of P.A. 94-235, the *Napoletano* plaintiffs seek a declaratory judgment determining:

"1. That Plaintiff is listed as a participating physician in [CIGNA]'s plan, filed with the Commission on Hospitals and Health Care as of October 1, 1994.

"2. That the Plaintiff has been removed from [CIGNA]'s list without being informed of the criteria Plaintiff's practice fails to meet.

"3. That [CIGNA] failed to file the general criteria for its selection or termination of health care providers pursuant to [P.A. 94-235 (e) (1) and (2)].

"4. That [CIGNA] be required to disclose its general criteria for its selection or termination of physicians pursuant to [P.A. 94-235 (e) (1)].

"5. That [CIGNA] may not reject or terminate Plaintiff due to [CIGNA]'s failure to file criteria pursuant to [P.A. 94-235 (a) (2)].

"6. Such other equitable relief as the Court deems necessary and proper."

In the demand for relief under their claim for an alleged violation of P.A. 94-235, the *Hollis* plaintiffs seek a declaratory judgment determining:

"1. That Plaintiff's physician is listed as a participating physician in [CIGNA]'s plan, filed with the Commission on Hospitals and Health Care as of October 1, 1994.

"2. That the Plaintiff's physician has been removed from [CIGNA]'s list without being informed of the criteria Plaintiff's practice fails to meet.

"3. That CIGNA failed to file the general criteria for its selection or termination of health care providers under the Act.

"4. That Plaintiff's physician remain a participating physician in [CIGNA]'s plan.

"5. Such other equitable relief as the Court deems necessary and proper."

conceding that a claim that CIGNA failed to make the requisite filing under P.A. 94-235(e)(1) would not be preempted, CIGNA has essentially conceded that ERISA does not preempt a claim under P.A. 94-235(e)(2). Although a successful claim under P.A. 94-235(e)(2) would in effect require that CIGNA continue to employ the plaintiff physicians, such a result would not have an impermissible or burdensome effect on the administration of the plan; see *Thiokol Corp., Morton International, Inc. v. Roberts*, supra, 76 F.3d at 757-58; *Greenblatt v. Delta Plumbing & Heating Corp.*, supra, 68 F.3d at 574; because it would simply enforce CIGNA'S plan as CIGNA created it. CIGNA is free to establish a health benefit plan as it chooses--the plaintiffs are not seeking to require that it adopt a plan with certain features. See *NYS Health Maintenance Organization Conference v. Curiale*, supra, 64 F.3d at 801. Upon adopting such a plan, however, P.A. 94-235, which CIGNA concedes is not per se preempted, requires that CIGNA file with the commission "the general criteria for its selection or termination of health care providers" and thereafter prohibits the use of criteria that have not been filed to terminate a provider.[30] Public Acts 1994, No. 94-235(e)(1) and (2). Consequently, no part of the plaintiffs' claim under P.A. 94-235 relates to the administration of the plan and no part of their claim is preempted by ERISA.

Moreover, preemption of the plaintiffs' claims would not further the purpose of ERISA preemption, which is to permit

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[30] We note that, even having failed to make the requisite filing, CIGNA may still discharge a plaintiff physician as long as the physician "has been informed of the criteria that his practice fails to meet." Public Acts 1994, No. 94-235(e)(2).

the creation of a uniform body of employee benefit law and avoid multiple regulatory schemes. *Fort Halifax Packing Co. v. Coyne*, supra, 482 U.S. at 9-11; *Greenblatt v. Delta Plumbing & Heating Corp.*, supra, 68 F.3d at 574; *O'Shea v. First Manhattan Co. Thrift Plan & Trust*, supra, 55 F.3d at 113. Requiring CIGNA to enforce a plan that it has established according to law does not interfere with the adoption of uniform administrative practices.[31]

IV

Having concluded that ERISA does not preempt the plaintiffs' claims, we must next determine whether P.A. 94-235 confers a private cause of action affording declaratory relief. The parties agree that the act does not expressly provide a private cause of action. The plaintiffs, however, claim that the availability of a private cause of action is implied. "In determining whether a private remedy is implicit in a statute not expressly providing one, several factors are relevant. First, is the plaintiff one of the class for whose . . . benefit the statute was enacted . . . ? Second, is there any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one?

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[31] Because we conclude that the plaintiffs' claims in both cases are not preempted by ERISA, we need not address ERISA's savings and deemer clauses. *See* 29 U.S.C. § 1144(b)(2)(A) and (B) (1994); see footnote 19. Additionally, in light of our conclusion, we need not address the plaintiffs' claims in both cases that the trial court improperly declined to open the judgments to reconsider its rulings on CIGNA's motions to strike based on the Supreme Court's decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, supra, ___ U.S. ___, 115 S. Ct. at 1671.

. . . Third, is it consistent with the underlying purposes of the legislative scheme to imply such a remedy for the plaintiff?" (Citations omitted; internal quotation marks omitted.) *Cort v. Ash*, 422 U.S. 66, 78, 95 S. Ct. 2080, 45 L. Ed. 2d 26 (1975).[32]

We will examine the test as it relates to each class of plaintiffs. The act benefits the class of physician providers directly. The act benefits this class by mandating that a preferred provider network, such as that administered by CIGNA, file with the commission a list of participating physicians and a list of criteria for selecting or terminating health care providers. This filing benefits the *Napoletano* plaintiffs because they are able to determine whether they meet the criteria for selection and continued enrollment with CIGNA's health care network. Additionally, the act benefits a class of patients, such as the *Hollis* plaintiffs, by informing them which physicians are available if they take part in a particular plan and by informing them of the credentialing standards for these physicians.

Second, we do not find any indication, explicit or implicit, in the legislative history that the legislature intended either to create or to deny a private cause of action. The history is silent in this respect.

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[32] The Supreme Court lists a fourth factor in *Cort v. Ash*, supra, 422 U.S. 78, namely, whether "the cause of action [is] one traditionally relegated to state law, in an area basically the concern of the States, so that it would be inappropriate to infer a cause of action based solely on federal law?" Because we are not concerned with a federal law in determining whether P.A. 94-235 provides a private cause of action, this factor does not apply to our analysis.

Third, providing a private cause of action to the plaintiffs is consistent with the underlying purposes of P.A. 94-235. One purpose of the act is to give health care providers information by which they can determine whether they are eligible for participation in a network. See 37 H.R. Proc., Pt. 17, 1994 Sess., p. 5951; *id.*, p. 5956, remarks of Representative Joseph Courtney ("what this amendment seeks to do is . . . address some of the disclosure and notification problems that providers have . . . complained about in terms of their ability to communicate with provider organizations"). A second purpose is to provide information to the public to enable health care purchasers to make informed decisions regarding their choice of health plans and doctors. See *id.*, p. 5980, remarks of Representative Patrick J. Flaherty ("I hope that this legislation will allow all of us to go forward and make decisions based on more complete and accurate information"); *id.*, pp. 5981-82, remarks of Representative Christopher G. Donovan ("The consumer is not involved in the selection of the network providers as much as they could. There is no consumer report so to speak of the network providers which is given to the consumer, and I feel that if there is more consumer input in the choice of provider and more consumer input in the direction of health care, we can do better with our managed care networks in the state."). On balance, we are persuaded that, under the criteria set forth by the Supreme Court in *Cort v. Ash*, supra, 422 U.S. at 78, a private cause of action exists under P.A. 94-235 to enforce its provisions.

Additionally, where the legislature wishes to limit enforcement of a statute to an administrative body, it has expressly done so. See, e.g., Connecticut Environmental Protection Act (General Statutes § 22a-5, 22a-6a and 22a-6b

expressly vests enforcement power in commissioner); CUTPA (General Statutes § 42-110d, 42-110k, 42-110m and 42-110o delineate procedure by which commission is to enforce act). Notably, the legislature has not expressly limited authority to enforce P.A. 94-235 in the commission although it has done so in other sections of chapter 368c of the General Statutes. See, e.g., General Statutes § 19a-151 (commission has express power to regulate increased charges to patients); General Statutes § 19a-154 (commission has express authority to ensure proper application of provision regulating health care facility's transfer of ownership); General Statutes § 19a-155 (commission must approve certain capital expenditures by health care agency); General Statutes § 19a-156 (commission has authority to approve, deny or modify hospital's proposed budget); General Statutes § 19a-167j (commission has authority to impose civil penalty upon health care facility that fails to file certain requested information, not including that information pursuant to P.A. 94-235). "The use of different words [or the absence of repeatedly used words in the context of] the same [subject matter] must indicate a difference in legislative intention." (Internal quotation marks omitted.) *Plourde v. Liburdi*, 207 Conn. 412, 416, 540 A.2d 1054 (1988); see *Angelsea Productions, Inc. v. Commission on Human Rights & Opportunities*, supra, 236 Conn. at 694-95. The absence of similar express limitations in P.A. 94-235 supports our conclusion that the act permits a private cause of action.

Furthermore, we discern from the legislative history that to effectuate fully the purposes of P.A. 94-235 of providing health care providers with information so that they can determine whether they are eligible to join a network and of providing the public with information about their choice of

health plans and physicians so that they can make informed decisions, "private interests [would not be] amply served without private causes of action." *Antinerella v. Rioux*, 229 Conn. 479, 495, 642 A.2d 699 (1994). Because the act does not provide a mechanism enabling private individuals to file grievances, private persons would be denied all access to the administrative enforcement process in the absence of a private cause of action. Cf. Connecticut Environmental Protection Act (General Statutes § 22a-13 provides that council on environmental quality is empowered to receive citizen grievances alleging violation of any statute regarding environmental quality). Accordingly, we conclude that P.A. 94-235 confers a private cause of action for declaratory relief upon the plaintiffs.

We reverse the judgments of the trial court and remand the cases to the trial court for further proceedings according to law.

In this opinion the other justices concurred.

APPENDIX B

SUPERIOR COURT OF CONNECTICUT JUDICIAL DISTRICT OF HARTFORD - NEW BRITAIN

Nos. 705357, 705358

F. BARRETT HOLLIS, et al. v.
CIGNA HEALTHCARE OF CONNECTICUT, INC.;
ROBERT S. NAPOLETANO, M.D., et al. v.
CIGNA HEALTHCARE OF CONNECTICUT, INC.

December 5, 1994, Decided
December 5, 1994, FILED

CONSOLIDATED MEMORANDUM OF DECISION RE MOTIONS TO STRIKE

I. INTRODUCTION

On Labor Day 1974, President Ford signed into law the Employee Retirement Income Security Act of 1974, popularly known as ERISA. 88 Stat. 829 (1974). ERISA, as it is well known, was intended to safeguard the pensions of American workers, but its sweep is much broader than that. It "sets out a comprehensive system for the federal regulation of private employee benefit plans, including both pension plans and welfare plans." *District of Columbia v. Greater Washington Board of Trade*, 121 L. Ed. 2d 513, 113 S. Ct. 580, 582 (1992). One of the cornerstones of this comprehensive system is a preemption provision, codified at 29 U.S.C. § 1144, that, while complicated, "is conspicuous

for its breadth." *FMC Corp. v. Holliday*, 498 U.S. 52, 58, 112 L. Ed. 2d 356, 111 S. Ct. 403 (1990). The motions to strike that are now before me present the question of whether § 1144 preempts the state law tort, contract and statutory claims contained in two companion cases. For the reasons set forth below, I conclude that all of these claims are preempted.

II. THE CAUSES OF ACTION

The allegations presented in the amended complaints filed in these companion cases -- which, for purposes of the respective motions to strike, I assume to be true -- arise from the unilateral decision of CIGNA, an issuer of health insurance, to remove certain physicians from its list of participating physicians. The two cases here were apparently brought in concert. *Hollis* presents the claims of a number of patients; *Napoletano* presents the claims of a number of physicians. The causes of action asserted in these cases must be described in some detail.

A. *Hollis*

Hollis is an action brought by nine plaintiffs, each of whom asserts four causes of action.

F. Barrett Hollis, the named plaintiff, alleges that he was insured for medical benefits under a group insurance plan between CIGNA and his wife's employer. He began cancer treatment with Dr. Raphael Cooper, a participating physician in CIGNA's Health Care Network. In May 1994, CIGNA decided to remove Dr. Cooper from its list of participating physicians as of September 1994. At about this time, CIGNA sent a letter to its Health Care members stating that its "goal is to establish a comprehensive network of quality

doctors who meet [CIGNA's] credentialing standards." Hollis claims that this letter is misleading because Dr. Cooper meets these standards. A few months later, CIGNA sent a second letter to its participants stating that, if their providers "choose[] not to participate," their care would be transferred to participating providers. Hollis claims that this letter is misleading in that it does not reflect that the removal decision was unilateral. At about the time of this second letter, CIGNA placed an advertisement in the Hartford Courant listing a number of participating physicians. This advertisement is assertedly false because it misrepresents which physicians are allowed to re-enroll in CIGNA's network. Finally, CIGNA sent its participants a directory of providers that is allegedly misleading because it fails to indicate that physicians can be removed from the list without notice.

The first count of Hollis' amended complaint alleges that CIGNA's actions violate the Connecticut Unfair Insurance Practices Act (CUIPA), specifically the prohibitions against misrepresentations and false information and advertising contained in Conn. Gen. Stat. § 38a-816. The second count alleges that these actions violate the Connecticut Unfair Trade Practices Act (CUTPA) in that they were unfair or deceptive acts or practices in violation of Conn. Gen. Stat. § 42-110b(a). The third count alleges that CIGNA has violated 1994 Conn. Acts 94-235, entitled An Act Concerning Managed Care, by removing Dr. Cooper from its plan even though Dr. Cooper is listed as a provider in CIGNA's filing with the Commission on Hospitals and Health Care and by failing to inform Dr. Cooper of the criteria that he has failed to meet. The fourth count alleges that these various acts constitute the common law tort of

misrepresentation.

The causes of action of the remaining eight plaintiffs are substantially similar to those asserted by Hollis. Each Plaintiff claims that he or she was, either through the plaintiff's own employment or that of a spouse, a participant in a CIGNA health plan. Each plaintiff began treating with a participating physician who was subsequently removed from CIGNA's list of participating physicians. Each plaintiff asserts the four causes of action asserted by Hollis.

CIGNA has filed a motion to strike the entire amended complaint, claiming that all causes of action asserted therein are preempted by ERISA.

B. *Napoletano*

Napoletano is an action brought by nine plaintiffs, each of whom asserts five causes of action.

Robert S. Napoletano, M.D., the named plaintiff, alleges that he is a physician licensed to practice in the State of Connecticut. He was a participating physician in the CIGNA Health Care Network and contracted with CIGNA through Pro Care Independent Practice Association, Inc. In May 1994, Napoletano received a letter from Pro Care informing him that CIGNA had unilaterally terminated its agreement with Pro Care as of September 1994. Napoletano claims that he continues to meet all of CIGNA's credentialing standards, that he is a third-party beneficiary of the contract between CIGNA and Pro Care, and that he was terminated without just cause.

The first three counts of Napoletano's amended complaint assert common law causes of action. The first count alleges

breach of contract. The second count alleges breach of an implied covenant of good faith and fair dealing. The third count alleges tortious interference with business expectancies. In making this third claim, Napoletano alleges that CIGNA made the various communications to its beneficiaries that have already been recounted in describing the Hollis complaint.

The fourth and fifth counts of Napoletano's amended complaint assert statutory causes of action. The fourth count alleges that CIGNA has violated Conn. Gen. Stat § 42-110b (CUTPA) by engaging in unfair or deceptive acts or practices. The fifth count alleges that CIGNA has violated 1994 Conn. Acts 94-235 by removing him from it plan. The specific allegations set forth in Napoletano's fifth count are similar to those contained in Hollis' third count.

The causes of action of the remaining eight plaintiffs are substantially similar to those asserted by Napoletano. Each plaintiff alleges that he is a physician who contracted with CIGNA through Pro Care and was removed from CIGNA's list of participating physicians when CIGNA terminated its contract with Pro Care. Each plaintiff asserts the five causes of action asserted by Napoletano.

CIGNA has filed a motion to strike the entire amended complaint, claiming, as in Hollis, that all causes of action asserted therein are preempted by ERISA.

III. DISCUSSION

A. ERISA Preemption Principles

Whether the causes of action asserted here are preempted by ERISA is a question of statutory interpretation. The

statute in question, as mentioned, is 29 U.S.C. § 1144, which provides, in relevant part, as follows:

(a) Supersedure ....

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title....

(b) Construction and application .... (2)

(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

Each of the three clauses just quoted has come to be known by a popular name. The first clause is the preemption clause. The second clause is the saving clause. The final clause is the deemer clause. *FMC Corp. v. Holliday*, supra, 498 U.S. at 58. The interpretation of these

three clauses -- individually and in combination -- has caused twenty years of judicial perplexity, with no obvious end in sight. The Supreme Court has diplomatically stated that they "are not a model of legislative drafting." *Metropolitan Life Insurance Co. v. Massa-chusetts*, 471 U.S. 724, 739, 85 L. Ed. 2d 728, 105 S. Ct. 2380 (1985), while the Second Circuit has more candidly described § 1144 as "a veritable Sargasso Sea of obfuscation," *Travelers Insurance Co. v. Cuomo*, 14 F.3d 708, 717 (2d Cir. 1993), *cert. granted*, 115 S. Ct. 305 (1994).

Although the statutory text is confusing, § 1144 has been considered by the Supreme Court on a number of occasions, and a number of reasonably clear principles have emerged from the Court's decisions. These principles are grounded not only in the statutory language but in "the structure and purpose of the statute." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138, 112 L. Ed. 2d 474, 111 S. Ct. 478 (1990).

First and foremost, "the pre-emption clause is conspicuous for its breadth." *FMC Corp. v. Holliday*, supra, 498 U.S. at 58. The focal point of this breadth is the word "relate." The Supreme Court held early on that, "A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97, 77 L. Ed. 2d 490, 103 S. Ct. 2890 (1983). "This reading is true to the ordinary meaning of 'relate to,' *see* BLACK'S LAW DICTIONARY 1288 (6th ed. 1990), and thus gives effect to the 'deliberately expansive' language chosen by Congress." *District of Columbia v. Greater Washington Board of Trade*, supra, 113 S. Ct. at 583 (quoting *Pilot Life Insurance Co. v.*

Dedeaux, 481 U.S. 41, 46, 95 L. Ed. 2d 39, 107 S. Ct. 1549 (1987)).

A second, related, principle is that the spectrum of laws preempted by ERISA is considerably broader than the subject matter of ERISA. The focal point of this principle is the statute's preemption of "any and all State laws." "State law" is defined as including "all laws, decisions, rules, regulations, or other State action having the effect of law, of any State." 29 U.S.C § 1144 (c)(1). Congress, in enacting § 1144, specifically decided "to pre-empt state laws relating to benefit plans, rather than those laws relating to subjects covered by ERISA." *Shaw v. Delta Air Lines, Inc.*, supra, 463 U.S. at 98 n.19. This is because "one of ERISA's main objectives was to eliminate State regulation of employee benefit plans." *NYSA-ILA Medical & Clinical Services Fund v. Axelrod*, 27 F.3d 823, 826 (2d Cir. 1994). Because of this fact, "ERISA pre-empts any state law that refers to or has a connection with covered benefit plans . . . 'even if the law is not specifically designed to affect such plans, or the effect is only indirect,' *Ingersoll-Rand*, supra, 498 U.S., at 139 . . . and even if the law is 'consistent with ERISA's substantive requirements,' *Metropolitan Life*, supra, 471 U.S. at 739." *District of Columbia v. Greater Washington Board of Trade*, supra, 113 S. Ct. at 583. "Even in the absence of an express link to an employee benefit plan, State law is preempted 'insofar as' the law applies to benefit plans in particular cases. (*Shaw v. Delta Air Lines*, supra, at 97 n.17....)." *Morgan Guaranty Trust Co. v. Tax Appeals Tribunal*, 80 N.Y.2d 44, 599 N.E.2d 656, 659, 587 N.Y.S.2d 252 (N.Y. 1992).

A third principle, however, is that ERISA preemption is

not without limitations. The exact scope of these limitations is not entirely clear. Shaw recognized that, "Some state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." 463 U.S. at 100 n.21. Unhappily, when it announced this limitation, the Court expressed "no views about where it would be appropriate to draw the line." *Id.* In order to assess where the line should be drawn, it is helpful to consider the only two cases in which the Court has found state actions to have a sufficiently "tenuous" connection with covered plans to survive preemption.

In *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 96 L. Ed. 2d 1, 107 S. Ct. 2211 (1987), the Court held that a Maine statute requiring employers to provide a one-time severance payment to employees in the event of a plant closing was not preempted. The Court reasoned that the law in question related to a benefit rather than a "plan." "Only a plan," it explained, "embodies a set of admin-istrative practices vulnerable to the burden that would be imposed by a patchwork scheme of regulation." *Id.* at 11-12. "The focus of the statute," it concluded, "is on the administrative integrity of benefit plans -- which presumes that some type of administrative activity is taking place." *Id.* at 15.

In *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 100 L. Ed. 2d 836, 108 S. Ct. 2182 (1988), the Court held that ERISA does not forbid garnishment of a benefit plan where the purpose is to collect judg-ments against plan participants. The Court reasoned that "several types of civil suits . . . can be brought against ERISA welfare benefit plans." *Id.* at 832. ERISA specifi-cally

authorizes certain civil enforcement actions to secure specified relief, including the recovery of plan benefits. 29 U.S.C. § 1132. In addition, "lawsuits against ERISA plans for run-of-the-mill State law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan ... are relatively commonplace." 486 U.S. at 833. Money judgments must be collectible in some way. The Court concluded that "garnishment is one permissible method." *Id.* at 834.

Balanced against *Fort Halifax* and *Mackey*, however, is *Pilot Life Insurance Co. v. Dedeaux*, supra. *Pilot Life* holds that ERISA preempts state common law tort and contract actions asserting improper processing of a claim for bene-fits under an insured employee benefit plan. These causes of action "relate to" an employee benefit plan. Because they were "based on alleged improper processing of a claim for benefits under an employee benefit plan, [they] undoubtedly meet the criteria for pre-emption." *Id.* at 48.

The Supreme Court, as mentioned, has left the dividing line between Mackey (which allows some "run-of-the-mill" tort actions) and Pilot Life (which broadly preempts many other tort actions) unclear, and, however this case is resolved, it is necessary to resort to first principles. The governing principle has been well stated by the Second Circuit in *Aetna Life Insurance Co. v. Borges*, 869 F.2d 142 (2d Cir.), *cert. denied*, 493 U.S. 811, 107 L. Ed. 2d 25, 110 S. Ct. 57 (1989). "What triggers ERISA preemption is not just any indirect effect on administrative procedures but rather an effect on the primary administrative functions of benefit plans, such as determining an employee's eligibility for a benefit and the amount of that benefit." *Id.* at 146-47.

Accord Airparts Co. v. Custom Benefit Services of Austin, Inc., 28 F.3d 1062, 1065 (10th Cir. 1994). ERISA thus "preempts claims challenging the administration of employee benefit plans." *MNVA Railroad, Inc. v. John Alden Life Insurance Co.*, 507 N.W.2d 15, 18 (Minn. Ct. App. 1993). (Emphasis in original.) As the Seventh Circuit has pithily explained, if a participant goes to a plan office and slips on a banana peel, that participant can bring a negligence suit. A case involving the nature of plan benefits, however, "is not a banana-peel case." *Pohl v. National Benefit Consultants, Inc.*, 956 F.2d 126, 128 (7th Cir. 1992).

The preceding discussion of principles has focused on the preemption clause. The saving clause and the deemer clause raise complex issues of their own. "The saving clause returns to the States the power to enforce those state laws that 'regulate insurance,' except as provided in the deemer clause. Under the deemer clause, an em-ployee benefit plan governed by ERISA shall not be 'deemed' an insurance company, an insurer, or engaged in the business of insurance for purposes of state laws 'purporting to regulate' insurance companies or insurance contracts." *FMC Corp. v. Holliday*, supra, 498 U.S. at 58.

Each clause has some internal complexity of its own. The principal task in construing the saving clause is to define what is a law that "regulates insurance." In addressing this question, the Supreme Court has referred to the case law interpreting the phrase "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. § 1011, et seq. Three criteria have been used to determine whether a practice falls under the "business of insurance" for purposes of the McCarran-Ferguson Act: "first, whether the practice has the

effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129, 73 L. Ed. 2d 647, 102 S. Ct. 3002 (1982). (Emphasis in original.) *See Pilot Life Insurance Co. v. Dedeaux*, supra, 481 U.S. at 48-49. Under the McCarran-Ferguson Act, Pireno explains, "none of these criteria is necessarily, determinative in itself," but, rather, "all three criteria" must be examined. 458 U.S. at 129.

The deemer clause is also a clause of great complexity. *See FMC Corp. v. Holliday*, supra. Because the pre-emption and saving clauses are dispositive of the claims in this case, however, the deemer clause need not be con-sidered here.

These governing principles must now be applied to the various causes of action asserted in the amended complaints.

B. Application of the Principles

1. *Hollis*

a. CUIPA

The first question that must be addressed with respect to the CUIPA claims asserted in Hollis is whether these claims are preempted by the preemption clause. I con-clude that they are.

The CIGNA plan in question is plainly "an employee benefit plan" as that term is defined by ERISA. An "employee benefit plan" means "an employee welfare benefit plan." 29 U.S.C. § 1002(3). An "employee welfare benefit plan" is defined as "any plan, fund, or program ...

established or maintained by an employer .. for the pur-pose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits...." 29 U.S.C. § 1002(1). Each of the plaintiffs in *Hollis* is described in the amended complaint as being insured under a group insurance plan between CIGNA and an employer. The plaintiffs do not contend that this plan is anything other than "an employee benefit plan."

Hollis' CUIPA cause of action "relates to" the plan. As already discussed, the Supreme Court has broadly con-strued the term "relate to," requiring only "a connection with or reference to such a plan." *Shaw v. Delta Air Lines, Inc.*, supra, 463 U.S. at 97. Such a connection plainly exists here since references to the plan abound in the first count of the amended complaint. The only real question is whether the connection here is "too tenuous, remote or peripheral ... to warrant a finding that the [cause of action] 'relates to' the plan." *Id.* at 100 n.21. The connection here cannot be so described. This is because the plaintiffs challenge the administration of the plan in question.

This case is not analogous to *DiPietro Corp. v. Interactive Benefits Corp.*, 825 F. Supp. 459 (D. Conn. 1993), and *Pace v. Signal Technology Corp.*, 417 Mass. 154, 628 N.E.2d 20 (Mass. 1994), the principle authorities relied on by the plaintiffs in this regard. *DiPietro* was an action brought by an employer alleging, inter alia, misrepresentation and CUIPA violations. The complaint essentially alleged that the defendant insurance company had misrepresented the nature of the plan in selling that plan to the employer. *Pace* was an action brought by a discharged

employee who alleged that the defendant insurance company had falsely told him that his disability insurance would continue while he received severance pay. Acting in reliance on this representation, he did not obtain such insurance elsewhere and was, subsequently, disabled during the severance period.

Even on their own terms, *DiPietro* and *Pace* cannot be reconciled with controlling Second Circuit precedent. *See Smith v. Dunham-Bush, Inc.*, 959 F.2d 6 (2d Cir. 1992); *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966, 973 n.1 (S.D.N.Y. 1994) (both holding claims of reliance on insurance company representations to be preempted). But the claims advanced in Hollis are, in any event, quite different. There is no allegation in Hollis that CIGNA sold its plan to an employer by the use of misrepresen-tation or that the plaintiffs relied on some misrepresenta-tion to their detriment. The complaint here, rather, focuses on CIGNA's removal of certain physicians from its plan. This is, in essence, a complaint about plan administration. This is a core ERISA concern.

A moment's reflection will confirm why this is so. The preemption clause "was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting direc-tives among States or between States and the Federal Government." *Ingersoll-Rand Co. v. McClendon*, supra, 498 U.S. at 142. Allowing state law actions like the one here would subject plans and plan sponsors to burdens not unlike those that the preemption clause seeks to foreclose. It is entirely foreseeable that different state courts, construing a

wide array of state statutory provisions and common law principles, might develop different substan-tive standards governing the circumstances under which health plans could remove physicians from their lists. This would, in the language of *Ingersoll-Rand*, require "the tailoring of plans ... to the peculiarities of the law of each jurisdiction. Such an outcome is fundamentally at odds with the goal of uniformity that Congress sought to implement." *Id.*

The final question that must be addressed is whether the CUIPA cause of action, in spite of being preempted by the preemption clause, is saved by the savings clause. I conclude that it is not.

Three different judges of the United States District Court for the District of Connecticut, as well as two United States Magistrates, have held that claims under CUIPA are preempted by ERISA. *Fischman v. Blue Cross & Blue Shield of Connecticut*, 755 F. Supp. 528, 531 (D. Conn. 1990) (Dorsey, J.); *Bailey-Gates v. Aetna Life Insurance Co.*, No. 3:93CV01404 (D. Conn. Sept. 21, 1994) (Daly, J., approving recommended ruling of Margolis, Mag.); *Lazaroff v. Blue Cross & Blue Shield of Connecticut, Inc.*, 1989 WL 235958 (D. Conn. Jan. 11, 1989) (Daly, J.); *Stone v. Blue Cross & Blue Shield of Connecticut*, 1988 WL 146645 (D. Conn. Jan. 6, 1989) (Nevas, J., approving recommended ruling of Latimer, Mag.). Judge Daly's opinion in Lazaroff contains the most thorough analysis and carefully considers the three-prong analysis of Pireno and Pilot Life described above. He acknowledges that CUIPA satisfies the third Pireno prong (inquiring whether the cause of action is limited to entities within the insurance industry). It does not, however, meet either of the first two prongs. Judge

Daly explains that: CUIPA prohibits certain practices by insurers, but it does not directly or appreciably alter a policyholder's risk. Moreover, although CUIPA does affect the policy rela-tionship between the insurer and the insured by prohibit-ing various unfair practices, it is not integral to the policy relationship. Unlike other statutory provisions, *see, e.g.*, Conn. Gen. Stat. § 38-319 et seq. (no-fault motor vehicle insurance requirements), CUIPA does not regulate the in-surance contract itself. Because it regulates conduct surrounding the insurance contract rather than focusing on the nature of the contractual relationship between the insured and the insurer, CUIPA does not regulate the business of insurance under the second McCarranFerguson criterion. *See Roberson v. Equitable Life Assur. Soc. of U.S.*, 661 F. Supp. 416, 422 (C. D. Cal. 1987). More importantly, the remedies provided by CUIPA conflict with the civil remedies provided by ERISA in § 1132. As the Supreme Court has recently concluded,

> the detailed provisions of [§ 1132(a)] set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-based plan partici-pants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. *Dedeaux*, [481 U.S. at 54]. ERISA's enforcement pro-visions permit beneficiaries to recover benefits due them under the plan, to enforce existing rights under the plan, and to clarify future

> rights under the plan. 29 U.S.C. § 1132(a)(1)(B). In addition, a beneficiary may bring a civil action to enjoin any conduct that violates ERISA or the plan or to obtain other appropriate equitable relief. 29 U.S.C. § 1132 (a)(3). By contrast, CUIPA provides a private right of action for money damages resulting from unfair insurance practices.

Griswold v. Union Labor Life Ins. Co., 186 Conn. 507, 519-20, 442 A.2d 920 (1982). Such a supplementation of ERISA's civil enforcement provisions is contrary to congressional intent to provide an exclusive and comprehensive procedure for claims settlement. *Lazaroff*, supra, at 2-3. (Footnote omitted.) This analysis is persuasive. For the reasons stated by Judge Daly, the CUIPA cause of action is not saved by the saving clause. The motion to strike the CUIPA causes of action must consequently be granted.

Given the analysis already set forth, the remaining causes of action can be considered much more expeditiously.

b. CUTPA

Three cases recently decided by the United States District Court for the District of Connecticut hold that CUTPA claims against employee healthcare plans are preempted by ERISA. *Bailey-Gates*, supra; *Lazaroff*, supra; *Stone*, supra. The case for preemption here is even stronger than in the case of CUIPA, because the CUTPA claims, like the common law claims about to be discussed, do not fall within the scope of the saving clause. "They are based on state laws of general application that do not specifically regulate the insurance industry....Although they may have some

impact on the insurance industry and although insurers obviously can breach contractual obligations and engage in unfair trade practices, neither the common law actions nor CUTPA is specifically directed at insurance companies." *Lazaroff*, supra, at 2.

c. P.A. 94-235

1994 Conn. Acts 94-235, § (e)(1) requires each preferred provider network to file with the Commission on Hospitals and Health Care "the general criteria for its selection or termination of health care providers." Section (e)(2) then provides that, "If a network uses criteria that has not been filed pursuant to subdivision (1) of this subsection to judge the quality and cost-effectiveness of a health care provider's practice under any specific program within the network, the network may not reject or terminate the provider participating in that program based upon such criteria until the provider has been informed of the criteria that his practice fails to meet."

P.A. 94-235 does not on its face provide for a private cause of action. Assuming, without deciding, that such a cause of action exists, the cause of action asserted by the Hollis plaintiffs is plainly preempted by ERISA. Section (e) of the act has a direct impact on plan administration, and the potential for conflict in substantive law is obvious. If such a cause of action were allowed, it is entirely foreseeable that different states might develop different standards applicable to the same plan conduct, "requiring the tailoring of plans ... to the peculiarities of the law of each jurisdiction." *Ingersoll-Rand*, supra, 498 U.S. at 142. Such an outcome is fundamentally inconsistent with the preemption clause.

This cause of action is not saved by the saving clause. P.A. 94-235 is not on its face limited to practices within the insurance industry. This contrasts with the Virginia statute held to be "saved" in *Stuart Circle Hospital Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir.), *cert. denied*, 126 L. Ed. 2d 478, 114 S. Ct. 579 (1993), which expressly applied to "insurers." *Id.* at 501. Moreover, the agency designated for filing by P.A. 94-235 is not the Department of Insurance but the Commission on Hospitals and Health Care, which is part of the Department of Health Services. Conn. Gen. Stat. § 19a-148. Although P.A. 94-235 plainly has some impact on insurers, it is not a law that "regulates insurance" for purposes of the saving clause. The motion to strike this cause of action must consequently be granted.

d. Misrepresentation

The misrepresentation causes of action are preempted for reasons already explained. In the Second Circuit, at least, misrepresentation actions that affect plan administration much more tenuously than those asserted in *Hollis* are preempted under *Smith v. Dunham-Bush, Inc.*, supra. As explained above, however, the causes of action here go directly to plan administration and are plainly preempted. The motion to strike them must be granted.

2. *Napoletano*

a. Breach of Contract

The *Napoletano* causes of action are even more plainly preempted by ERISA than the causes of action asserted in Hollis. The *Hollis* complaint is concerned in part with misrepresentations made to plan beneficiaries, although its ultimate focus on CIGNA's removal of certain physicians

from its list is clear. *Napoletano*, in contrast, does not even have a misrepresentation veneer. It is a complaint brought by physicians who directly challenge their removal from the list. This is a direct challenge to plan administration and, as such, is preempted by ERISA. A number of courts have found that "ERISA preempts claims of breach of contract ... filed by plan participants against plan providers." *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966, 972 (S.D.N.Y. 1994) (citing authorities). The case for preemption is even stronger when a physician brings a breach of contract action disputing his removal from a plan's list of participating physicians. Conflict in the law governing such plans is inevitable if different states are allowed to develop different common law standards regulating the circumstances under which such contracts can be terminated. It is a conflict of this sort that the preemption clause was intended to foreclose. The motion to strike the breach of contract counts must be granted.

b. Breach of Implied Covenant of Good Faith and Fair Dealing

The same considerations govern the counts asserting breach of an implied covenant of good faith and fair dealing. The motion to strike these counts must be granted.

c. Tortious Interference with Business Expectancies

The same considerations again govern the counts asserting tortious interference with business expectancies. The common law tort invoked by these counts does not turn on the existence of an actual contract but, by its nature, does require that there be "business expectations" that the law will protect from interference. *Sportsmen's Boating Corp. v.*

Hensley, 192 Conn. 747, 753, 474 A.2d 780 (1984). Here, perhaps even more than in the breach of contract counts, the development of different state standards as to just what "expectations" the law will recognize between a plan and its participating physicians will result in the very patchwork of conflicting laws governing plan administration that the preemption clause was intended to avoid. The motion to strike these counts must be granted.

d. CUTPA

The preemption of CUTPA claims by ERISA has already been discussed with respect to *Hollis*. For the reasons discussed above, the case for preemption is even stronger here. The motion to strike the CUTPA counts must be granted.

e. P.A. 94-235

The preemption of private action claims based on P.A. 94-235, assuming for purposes of argument that a private right of action exists, has already been discussed with respect to *Hollis*. For the reasons discussed above, the case for preemption is even stronger here. The motion to strike the P.A. 94-235 counts must be granted.

IV. CONCLUSION

For the reasons set forth above, the motions to strike the entire complaints in *Hollis* and *Napoletano* are granted.

Jon C. Blue
Judge of the Superior Court

APPENDIX C

STATE OF CONNECTICUT
SUPREME COURT

NO. SC 15283

F. BARRETT HOLLIS, ET AL.
v.
CIGNA HEALTHCARE
OF CONNECTICUT, INC. : SEPTEMBER 18, 1996

ORDER

THE MOTION OF THE DEFENDANT, FILED AUGUST 1, 1996, FOR REARGUMENT EN BANC, HAVING BEEN PRESENTED TO THE COURT, IT IS HEREBY ORDERED DENIED.

BY THE COURT

/s/ FRANCIS J. DRUMM, JR.
CHIEF CLERK

STATE OF CONNECTICUT
SUPREME COURT

NO. SC 15282

ROBERT S. NAPOLETANO, M.D., ET AL.
v.
CIGNA HEALTHCARE
OF CONNECTICUT, INC. : SEPTEMBER 18, 1996

ORDER

THE MOTION OF THE DEFENDANT, FILED AUGUST 1, 1996, FOR REARGUMENT EN BANC, HAVING BEEN PRESENTED TO THE COURT, IT IS HEREBY ORDERED DENIED.

BY THE COURT

/s/ FRANCIS J. DRUMM, JR.
CHIEF CLERK

APPENDIX D

STATUTORY PROVISIONS INVOLVED

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

TITLE I -- PROTECTION OF EMPLOYEE BENEFIT RIGHTS

SUBTITLE B -- REGULATORY PROVISIONS

Part 5 -- Administration and Enforcement

ERISA § 502, 29 U.S.C. § 1132 (1994)

(a) Persons empowered to bring a civil action

A civil action may be brought --

(1) by a participant or beneficiary --

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain

other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

. . .

ERISA § 514, 29 U.S.C. § 1144 (1994)

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

. . .

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of

any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

CONNECTICUT UNFAIR TRADE PRACTICES ACT

Conn. Gen. Stat. § 42-110b (1992 and Supp. 1996)

(a) No person shall engage in unfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce.

(b) It is the intent of the legislature that in construing subsection (a) of this section, the commissioner and the courts of this state shall be guided by interpretations given by the Federal Trade Commission and the federal courts to Section 5 (a) (1) of the Federal Trade Commission Act (15 USC 45 (a) (1)), as from time to time amended.

(c) The commissioner may, in accordance with chapter 54, establish by regulation acts, practices or methods which shall be deemed to be unfair or deceptive in violation of subsection (a) of this section. Such regulations shall not be inconsistent with the rules, regulations and decisions of the federal trade commission and the federal courts in interpreting the provisions of the Federal Trade Commission Act.

(d) It is the intention of the legislature that this chapter be remedial and be so construed.

CONNECTICUT UNFAIR INSURANCE PRACTICES ACT

Conn. Gen. Stat. § 38a-816 (1992 & Supp. 1996)

The following are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

(1) Misrepresentations and false advertising of insurance policies. Making, issuing or circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement, sales presentation, omission or comparison which: (a) Misrepresents the benefits, advantages, conditions or terms of any insurance policy; (b) misrepresents the dividends or share of the surplus to be received, on any insurance policy; (c) makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy; (d) is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any life insurer operates; (e) uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof; (f) is a misrepresentation for the purpose of inducing or tending to induce to the lapse, forfeiture, exchange, conversion or surrender of any insurance policy; (g) is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or (h) misrepresents any insurance policy as being shares of stock.

CONNECTICUT MANAGED CARE ACT

Conn. Gen. Stat. § 19a-166b (Supp. 1996)

(a) As used in this section and subsection (b) of section 20-138b: . . . (3) "Preferred provider network" means an arrangement in which agreements relating to the health care services to be rendered by providers, including the amounts to be paid to the providers for such services, are entered into between such providers and a person who establishes, operates, maintains or underwrites the arrangement, in whole or in part, and shall include any provider-sponsored preferred provider network or independent practice association that offers network services. . . .

. . .

(b) All preferred provider networks shall file with the Commission on Hospitals and Health Care prior to the start of enrolment. Any preferred provider network existing as of October 1, 1993, shall file within sixty days of said date. All networks shall annually update said filing by July first commencing July 1, 1994. The filing required by such network shall include the following information, except where such information is filed with the insurance department: . . . (2) a general description of the preferred provider network, including its geographical service area, the names of the hospitals included in the network and the names listed by speciality, of the providers included in the network; and (3) the name and address of the person to whom applications may be made for participation.

. . .

(e) (1) Each preferred provider network shall file with

the Commission on Hospitals and Health Care and make available upon request from a provider, the general criteria for its selection or termination of health care providers. Disclosure shall not be required of criteria deemed by the network to be of a proprietary or competitive nature that would hurt the network's ability to compete or to manage health services. For purposes of this section, disclosure of criteria is proprietary or anticompetitive if it has the tendency to cause health care providers to alter their practice pattern in a manner that would circumvent efforts to contain health care costs and is proprietary if revealing criteria would cause the network's competitors to obtain valuable business information.

(2) If a network uses criteria that have not been filed pursuant to subdivision (1) of this subsection to judge the quality and cost-effectiveness of a health care provider's practice under any specific program within the network, the network may not reject or terminate the provider participating in that program based upon such criteria until the provider has been informed of the criteria that his practice fails to meet.

Supreme Court, U.S.
FILED
JAN 29 1997
CLERK

No. 96-968

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1996

CIGNA HEALTHCARE OF CONNECTICUT, INC.,

Petitioner,

v.

ROBERT S. NAPOLETANO, ET AL. and
F. BARRETT HOLLIS, ET AL.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE SUPREME COURT OF CONNECTICUT

BRIEF OF AMICUS CURIAE CONNECTICUT BUSINESS & INDUSTRY ASSOCIATION IN SUPPORT OF CIGNA HEALTHCARE OF CONNECTICUT, INC.'S PETITION FOR WRIT OF CERTIORARI

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INTEREST OF THE AMICUS CURIAE

The Connecticut Business & Industry Association ("CBIA") is the largest business and trade association in Connecticut, with approximately 10,000 members. Many CBIA members sponsor or administer ERISA employee health plans for their employees, and members include both in-state and multi-state employers. CBIA assists its members in identifying and choosing effective and cost efficient health care providers and employee benefit plan third-party administrators. CBIA and its members therefore absorb the direct impact of state laws that add to health plan administrative complexity and interfere with sound plan administration, as threatened by the state law claims of the *Hollis* and *Napoletano* plaintiffs.

CBIA submits this *amicus curiae* brief in support of CIGNA HealthCare of Connecticut, Inc.'s petition for a writ of certiorari, with the written consent of all parties, copies of which accompany this brief pursuant to S. Ct. R. 37.2(a).

REASONS FOR GRANTING THE WRIT OF CERTIORARI

Summary of Argument

The Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, pre-empts the plaintiffs' state law causes of action because those actions seek to impose on plan administrators certain notice, reporting and contract compliance duties that conflict with ERISA's comprehensive disclosure scheme and because they seek to enforce plan provisions under a state law rubric that shadows the exclusive remedies provided by ERISA § 502, 29 U.S.C.

§ 1132. The posited state law duties would impose no mere theoretical, indirect or insubstantial administrative cost but a real, direct and substantial burden of complying with state statutory and common law requirements and answering in state court for any compliance lapse. Moreover, the very nature of the primary relief demanded -- reinstatement of physicians to a plan provider list -- strikes at the core structure of the ERISA plan and the ability of plan administrators to exercise efficient control over plan provisions.

Recognition of the plaintiffs' causes of action would open the floodgates nationwide to a tide of state regulation -- and private lawsuits -- seeking to "enforce" ERISA plan provisions. ERISA plan administrators would be forced to juggle the assertedly consistent but inevitably different provisions of ERISA and the laws of up to 50 states, including both statutory enactments and the common law. More significantly, they would be answerable to individual private complainants in state court under each state's interpretation of ERISA's requirements. The resulting administrative burden would stymie plan administrators in their efforts to control the costs of their plans and thereby threaten the very existence of employee health care plans. For these reasons CBIA writes to support the petition.

Argument

I. Allowing the Plaintiffs' Private State Law Claims Would Invite a Nationwide Patchwork of State Laws "Enforcing" Existing ERISA Plans.

The Connecticut Supreme Court has concluded that ERISA does not pre-empt the plaintiffs' private state law claims because the plaintiffs "do not attempt to prescribe the

substantive administrative aspects of a plan." Appendix to Petition for Writ of Certiorari ("App.") 33a. This theory of ERISA pre-emption would permit private state law enforcement actions so long as plaintiffs did not seek substantial revision of existing plan provisions. *See* App. 34a ("plaintiffs' claims merely turn on requiring CIGNA to enforce the benefit plan that it has already established and is maintaining"); App. 35a ("the *Napoletano* plaintiffs' claims simply assert that CIGNA has failed to enforce the employee benefit plan that it administers"). "Mere" enforcement of the plan as established, however, is the fundamental precept on which all of ERISA is built and is the key power that Congress has reserved to federal law and the federal courts. *E.g., Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987). ERISA does not pre-empt only those claims under state laws that are inconsistent with ERISA but all claims that "relate to" the plan. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985). Thus, it is not enough that the plaintiffs' private state law claims would leave the CIGNA plan intact; the claims cannot be based on state law that "relates to" the plan.

In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S. Ct. 1671, 1683 (1995), this Court carved out an exception to ERISA pre-emption for state laws that impose only an indirect economic influence and do not "bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself." The *Travelers* exception was applied where the state law served incidentally to make certain choices economically more attractive to administrators, but left the administrators free to "shop for the best deal." *Id.* at 1679. In effect, the type of indirect influence tolerated under *Travelers* is merely another market force acting on the health care delivery

system generally. *See, e.g., Moore v. Reynolds Metals Co. Retirement Program*, 740 F.2d 454, 456 (6th Cir. 1984) ("decisions [concerning benefits] are more appropriately influenced by forces in the marketplace and when appropriate, by federal legislation"), *cert. denied*, 469 U.S. 1109 (1985).

The rules of law created by the Connecticut Supreme Court are no mere market forces nor are they indirect or insubstantial in their intrusion on ERISA plan administration. The nine different state law private causes of action approved by the Connecticut court cut across state statutory and common law boundaries to permit plan participants and third-party service providers a mechanism, entirely separate from ERISA's comprehensive scheme, to enforce plan provisions. These nine state law provisions direct plan administrators to comply with plan provisions or face state law remedies, including injunctive relief demanded by private parties to restructure the plan to "original" specifications.

CBIA members who sponsor or administer plans for multi-state employee populations would be especially disadvantaged by Connecticut's spin on ERISA law. Instead of being subjected to the uniform federal regulation envisioned under ERISA, *see Ingersoll-Rand*, 498 U.S. at 142, multi-state plan administrators would be forced to view their administrative and fiduciary duties in light of the conflicting statutory and common law requirements of their multiple states, as well as the federal requirements. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 105 & n.25 (1983). It is not difficult to imagine, for instance, that physicians like Napoletano might be entitled to enforce third-party contract beneficiary rights under Connecticut law but not under the common law of Massachusetts or New York. Even the choice of applicable law for multi-state plans would present a legal morass. The

morass could only worsen as state legislatures throughout the country respond to the *Hollis* and *Napoletano* rulings by acting to "protect" their states' citizens from perceived inequities in ERISA plan administration and from the competing protective responses of their sister states.

It is no comfort to plan administrators that Connecticut requires "mere" plan compliance. Adequate notice, reporting, and contract compliance, as sought by the *Hollis* and *Napoletano* plaintiffs, exist not as abstract concepts but in the specific decisions of plan administrators. Administrators must decide whom to notify and how to do so, what to report to federal and state agencies, when to do so, and on what forms. They must decide whether excluding certain physicians comports with potentially conflicting requirements of the benefit plans and third-party contracts. These and myriad other decisions must be made, as efficiently and fairly as possible, for every plan participant and every contracted provider.

Before the *Hollis* and *Napoletano* decision, administrators in Connecticut looked only to federal law for guidance in making prudent decisions about notices, reports, and third-party contract compliance. After *Hollis* and *Napoletano*, administrators must also remain alert to state statutes and common law for additional "guidance" on the same subjects. Will the prudence and reasonableness of their actions be measured under ERISA rules in a federal court or by state rules in state court? This question must weigh heavily on administrators who bear personal liability for the prudence of their decisions. 29 U.S.C. §§ 1104, 1109. Administrators faced with the ambiguities inherent in the Connecticut Supreme Court's ruling must respond by taking excessive -- and therefore unnecessarily expensive -- precautions to satisfy

both federal and state requirements. This burden on plan administration is direct and substantial -- and untenable.

The Connecticut ruling presents more than a mere chilling effect on administrative decisionmaking; it sanctions a remedy that intrudes directly on the administrators' substantive choices of plan benefits by requiring that specific physicians be recognized as participating providers. For a plan that depends for its efficiency on its ability to limit the selection of providers, such an intrusion would be a virtual death knell. It is therefore essential that this fundamental ERISA issue be resolved by this Court and not, contrary to the intent of Congress, by state courts throughout the country applying their varying statutory and common law.

II. "Shadow" Enforcement of ERISA Plans Under State Law Would Drive Up the Cost of Plan Administration and Benefits.

CBIA and its members stand at the front line of a war on health care costs that has gripped this nation for 20 years or more[1]. ERISA encourages innovative efforts to control health care costs by relieving employee benefit plans of the burden of complying with state regulation. *E.g.*, *Travelers*, 115 S. Ct. at 1677; *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). Vital to innovation in the control of costs is an ERISA plan administrator's freedom to exercise dis-

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1 Connecticut and other New England states have experienced some of the highest individual healthcare costs in the nation. Katharine R. Levit, *et al.*, *Health Spending by State: New Estimates for Policy Making*, Health Affairs, Fall 1993 at 7, 14, 15.

cretion in the design and implementation of a plan. *See Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981) (pension plan details subject to discretion of plan designers). ERISA pre-emption is therefore appropriately aimed at state regulation that would interfere with plan administrators' exercise of discretion in pursuit of such urgently needed plan efficiencies. The patchwork of state statutory and common law requirements approved by the Connecticut Supreme Court in *Hollis* and *Napoletano* presents just the sort of regulatory interference that is targeted by ERISA's pre-emption provisions.

The freedom to innovate in response to rapid changes in the health care field is fundamental to ERISA plan design and administration. *See Alessi*, 451 U.S. at 525. Congress expressly invested employee welfare plans, including health care plans, with broad discretion to adapt to changing circumstances. *See* 29 U.S.C. § 1051(1) (exempting welfare plans from participation and vesting requirements applicable to pension plans); 29 U.S.C. § 1081a(1) (exempting welfare plans from funding requirements applicable to pension plans). The courts have long noted the need for room to adapt to changes in health care. *See, e.g., Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988) "[M]edical insurance must take account of inflation, changes in medical practice and technology, and increases in the costs of treatment independent of inflation." ERISA leaves health care plan administrators a wide path to do just that.

The Connecticut Supreme Court's ruling frustrates Congress' intention to permit innovative adaptation within the federally created and supervised bounds of ERISA. The ruling does not merely provide an economic incentive to select one choice over another, *cf. Travelers*, 115 S. Ct. at 1683, but cuts off all choices that are not, in the unique view

of Connecticut state courts, legally and equitably consistent with existing plan provisions *and* with Connecticut's statutory and common law. The creation of a private cause of action for damages and injunctive relief belies any comparison with the permissible economic incentives outlined in *Travelers*.

One of the primary innovations in the delivery of health care services has been selectively contracted provider networks like CIGNA's. The dramatic increase of such managed care programs has contributed to a sustained reduction in the rate at which health care costs are growing nationwide. The medical care component of the consumer price index for 1996 increased by 3 percent, the smallest annual increase in 31 years according to the Bureau of Labor Statistics. (Bureau of National Affairs, Health Care Policy Report 117 (Jan. 20, 1997). This gratifying result followed a consistent trend through the 1990s: 9.6 percent in 1990; 7.9 percent in 1991; 6.6 percent in 1992; 5.4 percent in 1993; 4.9 percent in 1994; 3.9 percent in 1995. *Id.*

A provider network is most efficient when it includes an optimal number of highly skilled providers in each specialty to meet the needs of the subscriber population. It is by limiting the number and types of providers included in a network that an insurer is able to implement cost reductions in services for health beneficiaries. *See HCA Health Servs. of Virginia, Inc. v. Metropolitan Life Ins. Co.*, 752 F. Supp. 202, 204 (E.D. Va. 1990), *appeal dismissed*, 957 F.2d 120 (4th Cir. 1992). Providers benefit from guaranteed access to the large patient population; the plan benefits from its ability to negotiate lower health care delivery costs per capita or per provider. Interference with the selective relationship between plan and provider disrupts this balance and threatens to eliminate preferred provider networks as an economically viable option for plan administrators. *See Ball Memorial*

Hosp., Inc. v. Mutual Hosp. Ins., Inc., 784 F.2d 1325, 1343 (7th Cir. 1986) (Indiana's PPO statute held not to require admission of any willing provider because doing so would inhibit PPO's ability to negotiate cost-effective provider agreements). Permitting individual plaintiffs to demand damages and injunctive relief would transform this disruptive influence into a genuinely destructive force.

Finally, a plan's method of advising participants of plan provisions, such as the names of approved providers on a list that varies over time, is a key contributor to the administrative efficiency that can result from a properly managed health care delivery system. *See Fort Halifax Packing*, 482 U.S. at 9 (system efficiencies are "difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States"). Demands for specific notice and reporting of changes in the provider list, backed by threat of private suits for damages under state law, drastically increase administrative costs by requiring specific responses -- at the administrative level or in state court. This is not to suggest that employee benefit plans do not have important duties to communicate with their participants and comply with their own plan provisions, but the enforcement of those duties is a core ERISA concern that is exclusive to federal law and the federal courts. *Pilot Life*, 481 U.S. at 46; *Shaw*, 463 U.S. at 98-99.

In this case, the economic effects of the *Hollis* and *Napoletano* claims are neither indirect nor insubstantial. Rather, the Connecticut Supreme Court has ruled that individual plaintiffs may force CIGNA into a certain scheme of coverage by requiring adherence to plan requirements as interpreted by the state courts applying state law to measure adherence. If there is a distinction between forced "adoption" of a different scheme of coverage, as barred by

Travelers, 115 S. Ct. at 1683, and forced "adherence" to an existing scheme, as proposed by the Connecticut Supreme Court, that distinction must be explored under ERISA, not state law.

CONCLUSION

For the foregoing reasons, CBIA urges the Court to grant CIGNA HealthCare of Connecticut, Inc.'s petition for a writ of certiorari.

Respectfully submitted,

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In The

Supreme Court of the United States

October Term, 1996

CIGNA HEALTHCARE OF CONNECTICUT, INC.,

Petitioner,

v.

ROBERT S. NAPOLETANO, ET AL. AND
F. BARRETT HOLLIS, ET AL.,

Respondents.

On Petition For Writ Of Certiorari To The Supreme Court Of Connecticut

RESPONDENTS' BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether the Court should review a decision of the Supreme Court of Connecticut which held the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1001 et seq., did not preempt common law and state statutory causes of action by physicians terminated from a healthcare network without just cause under the rationale of *New York State Conference of Blue Cross and Blue Shield Plans vs. Travelers Insurance Co.*, 115 S. Ct. 1671 (1995).

2. Whether the Court should review a decision of the Supreme Court of Connecticut which held ERISA did not preempt common law and state statutory cause of action by patients of physicians who have been terminated from a healthcare network without just cause under the rationale of *Travelers.*

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RESPONDENTS' BRIEF IN OPPOSITION

Respondents Robert S. Napoletano, Jeffrey B. Steckler, Terrance K. Donahue, Robert Cosentino, Raphael Cooper, Paul Ceplenski, Ijaz Shafi, David Bass, David Belman, F. Barrett Hollis, Vinetta Hollis, Elaine Arnett, Ellen Gentile, Darlene Chiboyan, Margaret Cooper, Richard A. Johnson, Sharon W. Johnson and Dan Ludwinowicz respectfully request that this Court deny the Petition for Writ of Certiorari of CIGNA Healthcare of Connecticut, Inc. ("CIGNA") which seeks review of the judgment and opinion of the Connecticut Supreme Court in this case.

OPINIONS AND ORDERS BELOW

The Opinions and Orders of the Connecticut Supreme Court and the Connecticut Superior Court are accurately identified and reproduced in the Appendix to the petition.

STATEMENT OF THE CASE

The Statement contained in the Petition filed by CIGNA omits critical facts, accordingly the Petition does not contain all "facts material to the consideration of the question presented". Rule 14.1(g).

The Plaintiffs, Napoletano, Steckler, Donahue, Cosentino, Cooper, Ceplenski, Shafi, Bass and Belman ("*Napoletano*") are physicians who had participated in the healthcare network offered by the Defendant CIGNA.

The Plaintiffs Hollis, Hollis, Arnett, Gentile, Chiboyan, Cooper, Johnson, Johnson and Ludwinowicz (*"Hollis"*) are patients of the Plaintiff physicians and are participants and/or beneficiaries under various contracts of health insurance with CIGNA.[1] The *Hollis* Plaintiffs had commenced treatment with the *Napoletano* Plaintiffs. The *Napoletano* Plaintiffs had been for various periods of time participating physicians in the health care network offered by CIGNA. After medical treatment had begun the *Napoletano* Plaintiffs were unilaterally terminated from the network, even though the *Hollis* Plaintiffs had been provided with various assurances by CIGNA that their physician, who met and continued to meet CIGNA's credentialing standards, would continue to participate in their health care plan.

In August of 1994, two separate lawsuits were filed. Napoletano alleged an action for breach of contract, breach of implied covenant of good faith and fair dealing, tortious interference with business expectancies as well as violations of the Connecticut Unfair Trade Practices Act ("CUTPA"), Conn. Gen. Stat. §42-110a, et seq., as amended and the Connecticut Managed Care Act, Conn.

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[1] The specific contracts of insurance were not before the trial court. Since this case was decided by a Motion to Strike, Connecticut Practice Book §152 (App. 5), and judgment entered pursuant to Connecticut Practice Book §157 (App. 6), there is an insufficient record upon which to base a decision by this Court. This is significant because there are nine individual Plaintiffs in *Hollis*, employed by nine different employers, and each Plaintiff's contract of insurance and its terms are essential for a decision of this Court. These contracts were not before the trial court or the Supreme Court of Connecticut because of the nature of the judgment entered in this case.

Gen. Stat. §19a-166b. Hollis alleged common law acts of misrepresentation as well as violation of CUTPA, the Connecticut Unfair Insurance Practices Act ("CUIPA") pursuant to Conn. Gen. Stat. §38a-816 and the Managed Care Act.

CIGNA moved to strike all counts of both the *Hollis* and *Napoletano* complaints. The trial court agreed and granted CIGNA's motion to strike all counts of the complaint in both cases. The Plaintiffs in both cases appealed from the judgments of the trial court.

The Connecticut Supreme Court reversed and held:

> The essence of the Plaintiffs' claims do not relate to the administration of employee benefit plans. The claim and relief sought do not impermissibly, affect the plans – they do not attempt to prescribe the substantive administration aspects of a plan, such as a determination of an employee's eligibility, the nature and amount of employee benefits, the amount of an employer's contribution to a plan, and the rules and regulations under which the plan operates . . . The Plaintiffs' claims do not require the administrators to operate the plans differently, they do not force a plan to adopt a certain scheme of substantive coverage, they do not tell CIGNA what type of plan to adopt, what coverage to offer, or whom to cover.
>
> *Napoletano vs. Cigna Healthcare of Connecticut, Inc.*, 238 Conn. 216, 244, 680 A.2d 127 (1996).

The Connecticut Supreme Court based its decision on this Court's holding in *New York State Conference of Blue Cross & Blue Shield Plan vs. Travelers Insurance Co.*, ___ U.S. ___, 115 S. Ct. 1671 (1995); *District of Columbia vs. Greater*

Washington Board of Trade, 506 U.S. 125 (1992); *FMC Corp. vs. Holliday*, 498 U.S. 52 (1990); *Metropolitan Life Ins. Co. vs. Massachusetts*, 471 U.S. 724 (1985); *Shaw vs. Delta Air Lines, Inc.*, 463 U.S. 85 (1983).

REASONS FOR DENYING THE WRIT

The Petition raises no issue that warrants review. No significant or unsettled question of federal law is presented that has not already been settled by this Court. The Decision of the Connecticut Supreme Court is correct on the merits as to issues raised by this petition as well as the other state procedural and substantive grounds that were decided without regard for the questions raised by the petitioner. It is not contrary to ERISA or any of the applicable decisions of this Court.

SUMMARY OF ARGUMENT

The Petition raises no significant or unsettled questions of law that have not already been settled by this Court. Rule 10.(c). In *Travelers* the Court announced that a law that only affected indirectly the relative price of an insurance policy was no different than a myriad of state laws in areas traditionally subject to local regulations which Congress could not have possibly intended to eliminate. *Travelers*, supra at 1683. The Connecticut Supreme Court decided both *Hollis* and *Napoletano* in a way that is not in conflict with *Travelers*.

The common law and state statutory causes of action alleged by the Plaintiffs in *Napoletano* and *Hollis* do not

affect the employee benefit structure or their administration, do not bind employers or plan administrators to particular choices or preclude uniform administrative practice of their respective health plans. Finally the state law claims do not provide alternate enforcement mechanism to obtain plan benefits. *Travelers,* supra at 1678.

The decision of the Connecticut Supreme Court is also decided on other clear and independent state procedural and substantive grounds that do not involve federal questions and presumably are not under review by this petition. In addition to this fact, as was stated earlier, the facts and record below do not present issues to this Court that are of "sufficient general importance". See *United States vs. Nobles,* 422 U.S. 225, 241-242 n.16 (1975). Rule 10.

CIGNA argues that the decision below conflicts with this Court's decision in *Pilot Life Insurance Co. vs. Dedeaux,* 481 U.S. 41 (1987) and *Varity Corp. vs. Howe,* ___ U.S. ___, 116 S. Ct. 1065 (1996). This is not the case.

In avoiding the holding of the Connecticut Supreme Court that *Travelers* controls the outcome of this case CIGNA asserts that the decision in the court below is contrary to *Pilot Life* and that all claims presented are preempted per se. This argument is disingenuous. CIGNA conceded below that the statutory and common law causes of action were not preempted per se.[2] Further, it conceded that ERISA would not preempt a claim by Plaintiffs that CIGNA had failed to make the requisite filing as required by Conn. Pub. Act 94-235 (now codified

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[2] See *Napoletano,* supra at 243, n.25.

as Conn. Gen. Stat. 19a-166b); and while these issues are not raised by this petition they do show the weakness in CIGNA's argument for the granting of this petition. CIGNA has conceded that the claims raised below by *Napoletano* and *Hollis* are not preempted per se, and conceded that the claims arising under Conn. Gen. Stat. §19a-166b are not preempted, yet they maintain in this petition that whatever else is left is preempted. *Pilot Life* is only relevant if CIGNA were to maintain preemption per se which in light of its prior concession in the court below is not permissible. CIGNA also argues that the decision before the Court is in conflict with *Varity*, supra. This is not the case. *Varity* dealt with the proper interpretation of ERISA §502(a)(3), which is not an issue in the case at bar and was in no way affected by *Travelers*, supra. This can hardly be persuasive for the proposition advanced by CIGNA.

CIGNA argues that the decision below is in conflict with *Zuniga vs. Blue Cross and Blue Shield of Michigan*, 52 F.3d 1395 (6th Cir. 1995). In making this assertion CIGNA fails to note that the majority decision failed to recognize *Travelers*, supra[3] in its decision. This hardly is the kind of conflict that should justify granting the petition. Rule 10.(c).

For all of these reasons the petition should be denied.

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[3] The dissent in *Zuniga*, on the other hand, adopted the reasoning of *Travelers* and held that the breach of contract alleged by the Plaintiff was not preempted. *Zuniga*, supra at 1403.

I. The Decision Below Regarding the Napoletano Claim Is Not In Conflict With Decisions Of Federal Courts

The *Napoletano* respondents are the physicians who had treated the *Hollis* Plaintiffs as members of the CIGNA healthcare network. In a forty-five count complaint the physicians alleged they were licensed to practice in Connecticut, were participating physicians in the CIGNA healthcare network and that despite satisfying all of CIGNA's credentialling standards were unilaterally terminated without cause. Each physician also alleged that despite being board certified in his area of specialty and continuing to satisfy CIGNA's credentialling standards, he had been denied the opportunity to reenroll as a participating physician. The complaint additionally alleged that each plaintiff would remain in the directory of providers throughout the length of CIGNA's annual contract with the patient, that each plaintiff would have the choice to reenroll, and that it would be the decision of each plaintiff whether to reenroll.

In this case the trial court below ruled on a motion to strike, the function of which under Connecticut Practice is to test the legal sufficiency of a pleading. See Conn. Practice Book §152 (App. 5). The Connecticut Supreme Court in *Sheets vs. Teddy's Frosted Foods, Inc.*, 179 Conn. 471, 472, 427 A. 2d 385 (1980), stated that the role of the trial court is to admit all facts well pleaded, to construe them in favor of the plaintiff, and to determine whether the plaintiff has stated a legally sufficient cause of action.

In light of these allegations, the *Napoletano* Plaintiffs have asserted that CIGNA breached its contract with each

plaintiff, breached its obligation to deal in a manner consistent with good faith and fair dealing, tortiously interfered with each plaintiff's business and violated CUTPA and the Connecticut Managed Care Act. The complaint sought monetary damages and such other legal and equitable relief as the Court may deem necessary and proper for breach of contract, breach of good faith and fair dealing and tortious interference with business expectancies. The CUTPA count requested monetary damages, punitive damages pursuant to Conn. Gen. Stat. §42-110g(a) (App. 3), reasonable attorneys fees pursuant to Conn. Gen. Stat. §42-110g(d) (App. 3) and such other legal and equitable relief as may be. The Managed Care Act count requested declaratory judgment as to whether CIGNA violated Conn. Gen. Stat. §19a-166b, et seq., to compel compliance with the requirements of the act, to preclude plaintiffs' termination from the network based upon CIGNA's previous noncompliance with the act, and such other equitable relief as may be appropriate. The trial court struck all counts claiming they were preempted by ERISA. The decision below reversed the trial court in its entirety.

This factual and procedural background shows why the petition should not be granted.

The facts of this case are unique to this case. The allegations of the complaint must be accepted as well proven. *Sheets*, supra. That being the case, the assertion by the petitioner that the *Napoletano* claims are in conflict with *Zuniga* does not hold water. First of all, the petition fails to specify with sufficient accuracy, brevity and clarity what it means by state law causes of action for reinstatement and other relief asserted by physicians

terminated from a network which provides services to ERISA plans, and that alone should be fatal to the request for certiorari. Rule 14.4. Second, the trial court below struck all counts. Inasmuch as the Connecticut Supreme Court reversed this ruling in its entirety, do we infer, as the respondents believe, that the petitioner does not challenge the decision below in its entirety? If that is the case, then much of the *Napoletano* decision remains intact. Therefore any decision by this Court would theoretically be of a limited nature and not present the Court with any compelling reason for granting certiorari. Rule 10.

Further, as is stated elsewhere in this brief, the petitioner has conceded that the statutory and common law claims of the plaintiffs are not preempted per se; and it appears that the decision below was based on adequate and independent state grounds that are not presented by the petition. Clearly this is another indication that there is no compelling reason for granting certiorari. Rule 10.

The sum of all of the above reasons indicate that again, while the issues raised in *Napoletano*, rights of physicians in a managed healthcare network are in theory issues of great national concern, the facts presented by this case make it unique and of little relevance on a national scale.

The petitioners argument as to the applicability of *Zuniga*, supra, is also misplaced.

First of all *Zuniga*, presents a tortured procedural path upon which to base any similarity to the case at bar. While it does present a breach of contract claim within an ERISA preemption context, there are other issues that make it hard for the respondents to see its applicability in

such a way as to say there is a clear conflict between the decisions of *Napoletano* and *Zuniga*. Rule 10.(b).

Substantively it is also inapplicable. *Travelers* was decided by this Court on April 26, 1995. *Zuniga* was decided by the United States Court of Appeals for the Sixth Circuit on May 2, 1995. While it is understandable that the Sixth Circuit might not have been aware of *Travelers* given its date of decision, it is clear by the dissent's reference to it, *Zuniga*, supra at 1403, that the Court was aware of it yet failed to take it into account in its majority decision. While the rationale of the majority in *Zuniga* for ignoring *Travelers* is not the central issue here, one must question the petitioner in advancing an argument that *Napoletano* is in such direct conflict with *Zuniga* that it should justify this Court in granting its petition. Rule 10.(b).

The respondents have shown that *Zuniga* is neither procedurally nor substantively in conflict with the present case so as to warrant the granting of the petition.

II. The Decision Below Regarding The Hollis Claims Is Not Contrary To Decision Of This Court And Of The Federal Courts Of Appeal.

The Plaintiffs in *Hollis* are patients who had commenced treatment with the Plaintiff physicians in *Napoletano*. The *Napoletano* Plaintiffs were participating physicians for varying periods of time in the healthcare network offered by CIGNA Healthcare of Connecticut Inc. During the course of treatment the *Napoletano* Plaintiffs were unilaterally terminated from the CIGNA network. The nine *Hollis* Plaintiffs filed a thirty-six count

complaint. F. Barrett Hollis, typical of the other Plaintiffs, alleged that he had commenced medical treatment with a physician who participated in CIGNA's Healthcare Network. After he was treated for several months, CIGNA sent him a letter announcing changes to its healthcare network and removed his physician from the network. CIGNA sent another letter stating that his doctor chose not to enroll in its plan and that his case would be transferred to another participating provider. CIGNA then placed an advertisement in the Hartford Courant misrepresenting which physicians had been allowed to file an application to reenroll in CIGNA's network. The advertisement contained the names of Hollis' physician. Additionally, CIGNA sent Hollis a directory of providers which included his physician but failed to inform him that participating physicians could be removed without notice. These acts by CIGNA provided the basis for *Hollis*.

The Connecticut Supreme Court applied the rationale of *Travelers* to the facts presented by *Hollis* and found:

> The essence of the Plaintiffs' claims do not relate to the administration of employee benefits plans. The claim and relief sought do not impermissibly affect the plan – they do not attempt to prescribe the substantive administrative aspects of a plan, such as a determination of an employee's eligibility, the nature and amount of employee benefits, the amount of an employer's contribution to a plan, and the rules and regulations under which the plan operates. *Napoletano*, supra at 243, 244.

The Connecticut Supreme Court took care to conform its decision in this case to the decision of this Court. The

court below, by Justice Katz, began by analyzing the "ERISA quagmire", *id.* at 233; it conducted an exhaustive review of this Court's rulings on ERISA preemption with particular attention to *Travelers* and its significance. *Id.* at 238.

CIGNA argues that the *Hollis* claims are really claims to enforce a plan and, therefore, subject to preemption and ERISA's civil enforcement provision under ERISA §502(a)(1)(B), 29 U.S.C. §1132(a)(1)(B). CIGNA vaults to the enforcement mechanism without adequately dealing with whether or not the claim and relief sought relates to an ERISA plan.[4]

The Court below analyzed the phrase "relates to" by reviewing the intent of Congress and pertinent cases of the Court on that issue, e.g. *Shaw,* supra, at 96, 99; *Fort Halifax Packing Co. vs. Coyne,* 482 U.S. 1, 11 (1987); *Ingersoll-Rand Co. vs. McClendon,* 498 U.S. 133, 139 (1990); *District of Columbia,* supra, at 130 n.1; *Napoletano,* supra, at 234-238.

It also reviewed decisions of Courts of Appeal after *Travelers*[5], e.g. *Thiokol Corp., Morton International, Inc. vs. Roberts,* 76 F.3d 751, 757 (6th Cir. 1996); *Safeco Life Ins. Co. vs. Musser,* 65 F.3d 647, 653 (7th Cir. 1995); *Boyle vs.*

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[4] As was stated, *ante,* n.1, the specific contracts for the nine *Hollis* Plaintiffs are not part of the record given the state of the pleadings upon which judgment was entered.

[5] Notably missing from CIGNA's petition.

Anderson, 68 F.3d 1093, 1099, 1102-1105 (8th Cir. 1995), cert. denied, ___ U.S. ___, 116 S. Ct. 1266 (1996).[6]

The Connecticut Supreme Court in adopting the *Travelers* rationale went beyond the unhelpful text of §514(a) and the frustrating difficulty of defining its key terms such as "relate" to and looked instead to the objectives of the ERISA statute as a guide to the scope of the state laws that Congress understood would survive preemption. *Napoletano*, supra.

The Court in *Travelers*, referring to the objective of ERISA and its preemption clause found that Congress intended ERISA to preempt at least three categories of state laws that have some connection to an ERISA plan. First, Congress intended ERISA to preempt state laws that mandate employee benefit structures or their administration. *Travelers*, supra, at 1678. Second, Congress intended to preempt state laws that bind employers or plan administrators to particular choices or preclude uniform administrative practice, thereby functioning as a regulation of an ERISA plan itself. *Id.* at 1679. Third, Congress intended to preempt state laws providing alternative enforcement mechanisms for employees to obtain ERISA plan benefits. *Id.* at 1167.

CIGNA asserts that the state law claims regarding misrepresentation are really state law claims "to enforce" an employee benefit plan and therefore preempted. It is

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[6] Respondents are aware that this Court has granted certiorari to a relevant 2d Cir. decision, *DeBuono vs. NYSA-ILA Medical and Dental Service Fund* (No. 95-1594), cert. granted, 117 S. Ct. 292 (Oct. 14, 1996)

difficult to understand and respond to this assertion when the question presented fails to state with specificity to which claim of *Hollis* the petitioner is referencing.[7] See Rule 14.4. This confusion is compounded by the action of the petitioner where it conceded below that the statutory and common law causes of action are not preempted per se *Napoletano,* supra at 243 and when it conceded that Conn. Gen. Stat. §19a-166b is not preempted by ERISA. *Id.* at 246, 247.

The contradiction in the petitioner's position is obvious. This shows why the issues presented here only have relevance to the parties and not to the public at large. Simply stated, there may well be issues of national significance associated with this case but the facts and record as developed below mandate that any significant and important decision regarding these issues will have to come from a case other than the one at bar. Rule 10. The failure of a petitioner to present with accuracy, brevity and clarity what is essential to a ready and adequate understanding of the points requiring consideration will be sufficient grounds for denying the petition. Rule 14.4.

Even if we ignore these defects, the decision below is consistent with applicable prior decisions of this Court. The Court below performed a detailed analysis of the phrase "relates to" in accordance with the intent of Congress in enacting ERISA. It made reference to *Shaw vs. Delta Air Lines,* supra, *District of Columbia,* supra, and *Ingersoll-Rand,* supra, for the position that some state

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[7] *Hollis* alleged common law misrepresentation and violations of Conn. Gen. Stat. §42-110b, Conn. Gen. Stat. §38a-816 and Connecticut Managed Care Act, Conn. Gen. Stat. 19a-166b.

actions may affect employee benefits plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law relates to the plan. It noted that these cases were the exception to the broad approach this Court has taken in the past to the issue of preemption. It interpreted *Travelers* to be a retreat by this Court from the expansive view it had taken in the past. *Napoletano*, supra at 237.[8] This approach is well founded.

CIGNA urges this Court, without so stating, to return to a broad preemptive approach, ignoring what the respondents feel is at the heart of the Court's current thinking:

> Our past cases have recognized that the Supremacy Clause, U.S. Const. Art. VI, may entail preemption of state law either by express provision, by implication, or by a conflict between federal and state law . . . and yet, despite the variety of these opportunities for federal preeminence, we have never assumed lightly that Congress had derogated state regulations but instead have addressed claims of preemption with the starting presumption that Congress does not intend to supplant state law . . . Indeed, in cases like this one, where federal law is said to bar state action in fields of traditional state regulations . . . we have worked on the 'assumption' that the historic police powers

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[8] In addition to the case cited in the opinion, see *Crull vs. Gem Ins. Co.*, 58 F.3d 1386 n.3 (9th Cir. 1995); *Napoletano*, supra at 238, see also *Coyne & Delaney Co. vs. Selman*, 98 F.3d 1457, 1469, 1470 n.14 (4th Cir. 1996); see also Catherine L. Fisk, *The Last Article About The Language of ERISA Preemption? A Case Study of the Failure of Textualism*, 33 HARV. J. on Legis. 35 (1996).

> of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress . . . (case omitted) *Travelers,* supra at 1676.

CIGNA also boldly asserts that the decision of the Connecticut Supreme Court is in direct conflict with decisions of every federal court of appeals. (pet. brief p. 10).

The petitioner's brief fails to show how decisions cited by it and decided prior to *Travelers* support this assertion. The cases cited by the petitioner after *Travelers, Crull,* supra and *Wolf vs. Reliance Std. Life Ins. Co.,* 71 F.3d 444, 447 (1st Cir. 1995) are clearly distinguishable on their facts from those presented in this case. The petitioner conveniently ignores the Federal Circuits following *Travelers* that the Connecticut Supreme Court referred to, e.g. *Thiokol Corp,* supra (challenge to Michigan Business Tax not preempted); *Safeco,* supra (suit on fees imposed by Wisconsin on health insurer not preempted; and *Boyle,* supra (challenge to provide a Minnesota health care reform legislation not preempted).

CIGNA also asserts that the *Hollis* misrepresentation claims, again without specifically identifying them, have clearly been preempted by *Varity,* supra. *Varity* can hardly be applicable to a decision based on *Travelers* when *Varity* fails to refer to *Travelers.* The rationale is clear. *Varity* concerned representations made to plan beneficiaries by their employer concerning their benefit plans. Employees filed suit under ERISA. The relevant question decided was whether ERISA §502(a)(3) authorized an action for individual relief. The petitioner on the other hand believes that the *Hollis* plaintiffs have a claim under 502(a)(1)(B). (pet. brief P.9). This inconsistency

shows why reference to *Varity* is unpersuasive on the substance of the issue as well.

Further, if we assume, arguendo, that the *Hollis* claims for misrepresentation are preempted as CIGNA urges, that still would leave all non-misrepresentation claims that the Plaintiffs have asserted intact. If that result were to occur a decision by this Court would clearly be of limited significance and have no effect beyond that to the parties to the lawsuit, as the remainder of the lawsuit will be allowed to proceed.

Therefore, it is clear that the decision below is not in conflict with prior decisions of this Court and no special or important reason exists for the granting of this petition.

III. The Decision Below Does Not Undermine Congressional Policies That Underlie ERISA

The decision below is an appropriate decision by the highest court of a state in response to allegations of a general business tort nature. It applied the reasoning of this Court in *Travelers* to claims by the *Hollis* and *Napoletano* plaintiffs concerning action taken by CIGNA in the State of Connecticut. It is a matter of local concern. The petitioner attempts to interject issues that are totally extraneous to the decision at bar. While the issues of ERISA welfare plans and managed care are of national importance, the facts and holding of this case do not present this Court with the case upon which to promulgate a general pronouncement on the relationship between ERISA preemption and managed care.

Further, by raising these issues along with reference to "any willing provider" or other similar regulation (See pet. brief 18-20), one must ask if the petitioner is seeking review under Rule 10.(b) (conflict between state court of last resort and federal court of appeals) or Rule 10.(c) (a state court has decided an important question of federal law which has not been, but should be settled by this Court) or merely just an advisory opinion.

The petitioner has failed to show how the decision below has undermined the congressional policies that underlie ERISA. Rather it offers an unfocused legal proposition, concerning ERISA preemption and managed care issues, to this Court that were not presented or decided by the opinion below. The petitioner has the duty to present its argument with accuracy, brevity and clarity. Rule 14.4. Since it has failed to do so, the petition should be denied. While litigation over ERISA preemption and laws regulating managed care may very well increase, that can hardly be sufficient reason, let alone compelling reason, to overcome the defects in CIGNA's petition.

Accordingly, the petitioner fails to state sufficient grounds to grant the petition and, therefore, it should be denied.

CONCLUSION

For all of the above reasons this Court should deny the Petition for Certiorari on all questions presented.

Respectfully submitted,

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§ 38a-815. Unfair practice prohibited.

No person shall engage in this state in any trade practice which is defined in section ***38a-816*** as or determined pursuant to sections 38a-817 and 38a-818 to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance, nor shall any domestic insurance company engage outside of this state in any act or practice defined in subsections (1) to (12), inclusive of section ***38a-816***. The commissioner shall have power to examine the affairs of every person engaged in the business of insurance in this state in order to determine whether such person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by sections 38a-815 to 38a-819, inclusive. When used in said sections, "person" means any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including agents, brokers and adjusters.

§ 38a-816. Unfair practices defined

The following are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

(1) Misrepresentations and false advertising of insurance policies. Making, issuing or circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement, sales presentation, omission or comparison which: (a) Misrepresents the benefits, advantages, conditions or terms of any insurance

policy; (b) misrepresents the dividends or share of the surplus to be received, on any insurance policy; (c) makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy; (d) is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any life insurer operates; (e) uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof; (f) is a misrepresentation for the purpose of inducing or tending to induce to the lapse, forfeiture, exchange, conversion or surrender of any insurance policy; (g) is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or (h) misrepresents any insurance policy as being shares of stock.

(2) False information and advertising generally. Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation, or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

§ 42-110g. Action for damages. Class actions. Costs and fees. Equitable relief

(a) Any person who suffers any ascertainable loss of money or property, real or personal, as a result of the use or employment of a method, act or practice prohibited by section 42-110b, may bring an action in the judicial district in which the plaintiff or defendant resides or has his principal place of business or is doing business, to recover actual damages. Proof of public interest or public injury shall not be required in any action brought under this section. The court may, in its discretion, award punitive damages and may provide such equitable relief as it deems necessary or proper.

(b) Persons entitled to bring an action under subsection (a) of this section may, pursuant to rules established by the judges of the superior court, bring a class action on behalf of themselves and other persons similarly situated who are residents of this state or injured in this state to recover damages.

(c) Upon commencement of any action brought under subsection (a) of this section, the plaintiff shall mail a copy of the complaint to the attorney general and the commissioner of consumer protection and, upon entry of any judgment or decree in the action, shall mail a copy of such judgment or decree to the attorney general and the commissioner of consumer protection.

(d) In any action brought by a person under this section, the court may award, to the plaintiff, in addition to the relief provided in this section, costs and reasonable attorneys' fees based on the work reasonably performed by an attorney and not on the amount of recovery. In a

class action in which there is no monetary recovery, but other relief is granted on behalf of a class, the court may award, to the plaintiff, in addition to other relief provided in this section, costs and reasonable attorneys' fees. In any action, brought under this section, the court may, in its discretion, order, in addition to damages or in lieu of damages, injunctive or other equitable relief.

(e) Any final order issued by the department of consumer protection and any permanent injunction, final judgment or final order of the court made under section 42-110d, 42-110m, 42-110o or 42l-110p shall be prima facie evidence in an action brought under this section that the respondent or defendant used or employed a method, act or practice prohibited by section 42-110b, provided this section shall not apply to consent orders or judgments entered before any testimony has been taken.

(f) An action under this section may not be brought more than three years after the occurrence of a violation of this chapter.

(g) In any action brought by a person under this section there shall be a right to a jury trial except with respect to the award of punitive damages under subsection (a) of this section or the award of costs, reasonable attorneys' fees and injunctive or other equitable relief, under subsection (d) of this section.

§ 152. Motion to Strike – In General

Whenever any party wishes to contest (1) the legal sufficiency of the allegations of any complaint, counterclaim or cross claim, or of any one or more counts thereof, to state a claim upon which relief can be granted, or (2) the legal sufficiency of any prayer for relief in any such complaint, counterclaim or cross complaint, or (3) the legal sufficiency of any such complaint, counterclaim or cross complaint, or any count thereof, because of the absence of any necessary party, or (4) the joining of two or more causes of action which cannot properly be united in one complaint, whether the same be stated in one or more counts, or (5) the legal sufficiency of any answer to any complaint, counterclaim or cross complaint, or any part of that answer including any special defense contained therein, that party may do so by filing a motion to strike the contested pleading or part thereof.

A motion to strike on the ground of the nonjoinder of a necessary party must give the name and residence of the missing party or such information as the moving party has as to his identity and residence and must state his interest in the cause of action.

§ 157. Motion to Strike – Substitute Pleading; Judgment

Within fifteen days after the granting of any motion to strike, the party whose pleading has been stricken may file a new pleading; provided that in those instances where an entire complaint, counterclaim or cross complaint has been stricken, and the party whose pleading has been so stricken fails to file a new pleading within that fifteen-day period, the court may upon motion enter judgment against said party on said stricken complaint, counterclaim or cross complaint. (1978.)

Supreme Court, U.S.
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No. 96-968

IN THE

Supreme Court of the United States

October Term, 1996

CIGNA HEALTHCARE OF CONNECTICUT, INC.,

Petitioner,

v.

ROBERT S. NAPOLETANO, ET AL. and
F. BARRETT HOLLIS, ET AL.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE SUPREME COURT OF CONNECTICUT

REPLY BRIEF FOR THE PETITIONER

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REPLY BRIEF FOR THE PETITIONER

Petitioner CIGNA HealthCare of Connecticut, Inc. hereby replies to the brief in opposition ("Opp.") filed by respondents.

1. There is a Clear Conflict Between the Decision Below and Decisions of this Court and Federal Courts of Appeal

Respondents argue that there is no conflict between the decision below and decisions of this Court and other federal courts. They correctly note that the Connecticut Supreme Court invoked this Court's decision in *New York State Conference of Blue Cross and Blue Shield Plans v.*

Travelers Insurance Co., 115 S. Ct. 1671 (1995) to hold that both the *Hollis* and *Napoletano* claims did not "relate to" ERISA-covered employee benefit plans and thus were not preempted by ERISA. (Opp. at 5.) The core of the Connecticut Supreme Court's rationale, however, was that the claims did not "relate to" ERISA plans because, as to *Hollis*, they "merely turn on requiring CIGNA to enforce" a benefit plan (App. 34a) and, as to *Napoletano*, they "simply assert that CIGNA has failed to enforce the employee benefit plan that it administers" (App. 35a). A holding that state law claims may be a vehicle to "enforce" an ERISA-covered plan is directly contrary to this Court's decisions in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987) and *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), both of which hold that ERISA itself provides the exclusive civil enforcement mechanism for such claims. As argued in the petition and recognized by several federal courts of appeal (Pet. 17-19), the *Travelers* analysis does not apply to such claims and does not affect the validity of *Pilot Life* or *Ingersoll-Rand*. Thus, there is a clear conflict warranting a grant of certiorari between the decision below and decisions of this Court and federal courts.[1]

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[1] The petition also argued that, to the extent the *Hollis* claims alleged misrepresentations to plan participants by administrators of ERISA plans, they were clearly preempted since ERISA itself provides a remedy in such circumstances. (Pet. 12-13, *citing Varity Corp. v. Howe*, 116 S. Ct. 1065 (1996).) Contrary to respondents' misperceptions, petitioner did not argue that *Varity* itself construes ERISA's preemption provisions. The significance of *Varity* is to underline the exclusive nature of the civil enforcement mechanism which provides avenues of relief for respondents under both §§ 502(a)(1)(B) and (a)(3) of ERISA; as *Pilot Life*

There is also a direct conflict between the treatment of the *Napoletano* claims in the decision below and the treatment of a closely parallel claim in *Zuniga v. Blue Cross and Blue Shield of Michigan*, 52 F.3d 1395 (6th Cir. 1995). Respondents argue that *Zuniga* is substantively "inapplicable," apparently on the theory that the majority opinion in the Sixth Circuit "failed to take...into account" the *Travelers* decision, which was issued roughly one week before *Zuniga* and is referred to in the *Zuniga* dissent. (Opp. at 10.) The *Zuniga* majority did not rely on *Travelers* but rather on *Ingersoll-Rand* in holding preempted claims which, like the claims in *Napoletano*, sought "benefits under the plan for...treatment of covered patients." 52 F.3d at 1401. Its apparent conclusion, in the face of the dissent's cite to *Travelers*, that *Travelers* did not govern the preemption analysis merely underscores the conflict between *Zuniga* and the decision below over whether, after *Travelers*, state laws may directly regulate plan administration.

2. The Petition Presents Issues of National Significance on a Record Suitable for Certiorari

Respondents concede, grudgingly, that the issues raised in the petition "are in theory issues of great national concern" (Opp. at 9) and "are of national importance" (*id.* at 17). They argue, however, that these cases are not suitable for certiorari, in part because of imagined defects in the petition and in part because of supposed concessions by petitioner in the court below and alleged "adequate and independent state grounds" for the decision below.

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holds, the existence of this exclusive mechanism requires preemption of parallel state law claims. *Pilot Life*, 481 U.S. at 51.

There were no grounds for the decision below other than the ERISA preemption issue presented in the petition, and respondents identify no such ground. The trial court granted petitioner's motion to strike respondents' claims on the ground that the claims were preempted by ERISA. (App. 65a.) The Connecticut Supreme Court reversed that decision, reinstating the claims. While the Connecticut Supreme Court also decided other state law issues in respondents' favor,[2] the preemption question was dispositive of the claims' legal sufficiency; if the claims had been held preempted by ERISA, their dismissal would have been upheld.[3]

Similarly, the supposed "concessions" by petitioner in the court below were merely recognitions that state common and statutory law that does not directly refer to ERISA plans is not preempted "*per se*" (App. 33a & n.25) and such law is not necessarily preempted as to all aspects of petitioner's business. Where, however, that state law is applied in a way that "relates to" ERISA plans -- as here, to "enforce" those plans -- it is preempted, and review by this Court is necessary and warranted to reestablish this principle.

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[2] Principally, the court held that there was a private right of action to seek declaratory relief under a state statute. (App. 44a.)

[3] Respondents complain that the petition fails to address separately the various claims asserted in *Hollis* (Opp. at 14) and suggest that the petition does not encompass all of the claims in *Napoletano* (*id.* at 9). The Connecticut Supreme Court used a single rationale to hold that *all* claims in both cases were not preempted; the petition presents a question regarding that rationale and encompasses all claims.

CONCLUSION

For the reasons stated here and in the petition for a writ of certiorari, the petition should be granted.

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